InFocus RADIOLOGY

Updated: 11 May 2023

MRI Safety Questionnaire

Name: _____ **Date of Birth:** _____

Address: _____

Please answer the following questions carefully. Answering incorrectly may be harmful to your health.
Please indicate if you have any of the following:

Cardiac pacemaker or defibrillator	☐ Yes	☐ No
Neurostimulator or other electronically activated device	☐ Yes	☐ No
Artificial heart valve	☐ Yes	☐ No
Cerebral (brain) aneurysm clip or embolization coils	☐ Yes	☐ No
Cochlear or inner ear implant	☐ Yes	☐ No
Stents	☐ Yes	☐ No
IVC filter	☐ Yes	☐ No
Intraventricular (brain) or spinal shunt	☐ Yes	☐ No
Joint replacement, pins, plates or screws	☐ Yes	☐ No
An implanted drug infusion device	☐ Yes	☐ No
Breast tissue expander or penile implant	☐ Yes	☐ No
Tattoo, permanent make up or body piercing jewellery	☐ Yes	☐ No
Dentures or false teeth, hearing aid or medication patch	☐ Yes	☐ No
Intra-uterine device (IUD) or Lap Band	☐ Yes	☐ No
Any other implanted item	☐ Yes	☐ No
Kidney disease (including renal transplant or solitary kidney)	☐ Yes	☐ No
Diabetes or high blood pressure	☐ Yes	☐ No

Please list all surgical and medical procedures you have had:

_____

_____

Have you ever had:

An eye injury involving metal	☐ Yes	☐ No
A bullet or shrapnel injury	☐ Yes	☐ No
An allergic reaction to any medication or contrast dye	☐ Yes	☐ No
Females: Are you pregnant?	☐ Yes	☐ No

I attest that the above information is correct to the best of my knowledge: ☐ Yes ☐ No

Patient Signature: _____ **Date:** _____

Radiographer: _____ **Date:** _____