# MRI Questionnaire

| Patient Name | Date of Birth |
|---|---|
| | |

**Please tell us whether or not you have a history of any of the following medical conditions:**

| | |
|---|---|
| Cardiac Pacemaker / Defibrillator | ☐ Yes ☐ No |
| Implanted Cardiac Monitor (Loop Recorder) | ☐ Yes ☐ No |
| Brain Aneurysm Clips | ☐ Yes ☐ No |
| Eye Implant / Ear Implant | ☐ Yes ☐ No |
| Hearing Aid | ☐ Yes ☐ No |
| Vascular/Surgical clips | ☐ Yes ☐ No |
| Shunts/Stents | ☐ Yes ☐ No |
| Pumps | ☐ Yes ☐ Noo |
| Prosthesis | ☐ Yes ☐ No |
| Wire Sutures | ☐ Yes ☐ No |
| Any Type of Stimulator (ie, Tens Unit, Bladder, Spine) | ☐ Yes ☐ No |
| Any Type of Foreign Body, Bullet, Iron | ☐ Yes ☐ No |
| Continuous Glucose Monitor | ☐ Yes ☐ No |
| Tattoo Eyeliner | ☐ Yes ☐ No |

**Is there any chance there could be metal in your eye?**
(Do you work with metal welding, cutting or grinding?) ☐ Yes ☐ No

**Do you have a history of cancer?** ☐ Yes ☐ No

**Are you pregnant or a nursing mother?** ☐ Yes ☐ No

**Any previous surgery?** ☐ Yes ☐ No

If yes, what kind and when _____

**Have you had any other testing for this problem?** ☐ MRI ☐ CT ☐ X-ray ☐ Ultrasound

If yes, where and when _____

**Comments**

| Patient Signature | Date |
|---|---|
| | |

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