

**Center for Sports Medicine & Orthopaedics**  
**MAGNETIC RESONANCE (MRI) PATIENT SCREENING FORM**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
Area of Body to be Examined: \_\_\_\_\_ Reason for MRI: \_\_\_\_\_

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All questions on the screening form should be answered completely to avoid confusion or misunderstanding as to the metal medical history and metal exposure history of the patient.

1. Have you ever had a prior surgical procedure of any kind? \_\_\_ YES \_\_\_ NO

If yes, please indicate the date (approximate if unknown) and type of surgery:

Type of surgery: _____	Type of surgery: _____
Type of surgery: _____	Type of surgery: _____
Type of surgery: _____	Type of surgery: _____
Type of surgery: _____	Type of surgery: _____
Type of surgery: _____	Type of surgery: _____
Type of surgery: _____	Type of surgery: _____
Type of surgery: _____	Type of surgery: _____
Type of surgery: _____	Type of surgery: _____
Type of surgery: _____	Type of surgery: _____
Type of surgery: _____	Type of surgery: _____

2. Have you ever experienced any problem related to previous MRI procedure? \_\_\_ YES \_\_\_ NO

If yes, please explain: \_\_\_\_\_

3. Are you claustrophobic? \_\_\_ YES \_\_\_ NO

If yes, did you take anything for sedation? \_\_\_ YES \_\_\_ NO

Do you have a driver? \_\_\_ YES \_\_\_ NO

4. Have you had an eye injury involving a metallic object or fragment (e.g., metallic slivers, shavings)? \_\_\_ YES \_\_\_ NO

5. Have you taken a camera pill recently? \_\_\_ YES \_\_\_ NO

If yes, did you confirm through visualization that the object was eliminated from your body? \_\_\_ YES \_\_\_ NO

**FEMALES ONLY:**

1. Are you or could you be pregnant? \_\_\_ YES \_\_\_ NO

Date of last menstrual period: \_\_\_\_\_

2. Are you taking fertility medication or treatments? \_\_\_ YES \_\_\_ NO

3. Are you breastfeeding? \_\_\_ YES \_\_\_ NO

4. Do you have an IUD / birth control implant? \_\_\_ YES \_\_\_ NO

# CAUTION

Magnetic resonance imaging (MRI) systems use strong magnetic fields and radio-frequency energy for imaging soft tissue in the body. Certain implants, devices, or objects may pose a hazard to individuals in close proximity to the magnet of the MRI system and/or may interfere with the MRI procedure.

**Please indicate if you currently have or ever had any of the following:**

Aneurysm clip(s)	__YES __NO	Medical patch (transdermal)	__YES __NO
Cardiac pacemaker/Implanted cardiac defibrillator	__YES __NO	(e.g., Nicotine, Nitroglycerine)	
Electronic implant or device	__YES __NO	Any metallic fragment or foreign body	__YES __NO
Magnetically activated implant or device	__YES __NO	Wire mesh implant	__YES __NO
Neurostimulator/Spinal Cord Stimulator	__YES __NO	Tissue expander (e.g., breast)	__YES __NO
Bone growth/bone fusion stimulator	__YES __NO	Surgical staples, clips, or metallic sutures	__YES __NO
Internal electrodes or wires	__YES __NO	Joint replacement (hip, knee, etc.)	__YES __NO
Cochlear, otologic or other ear implant (hearing aid)	__YES __NO	Bone/Joint pin, screw, nail, wire, plate, etc.	__YES __NO
Metallic stent, filter, or coil	__YES __NO	Braces, dentures or partial plates	__YES __NO
Insulin or other infusion pump	__YES __NO	Tattoo or permanent makeup	__YES __NO
External Blood Sugar Monitor (CGM)	__YES __NO	Body piercing jewelry	__YES __NO
Any type of prosthesis (e.g., eye, penile)	__YES __NO	Wig or Hair implants or extensions	__YES __NO
Heart valve prosthesis	__YES __NO	Hair accessories (e.g., hairpins)	__YES __NO
Blood clot filter	__YES __NO	Other implant	__YES __NO
Eyelid spring or wire; eye surgery; magnetic eyelashes	__YES __NO	Breathing problem or motion disorder	__YES __NO
Artificial or prosthetic limb	__YES __NO	CABG/Heart bypass surgery	__YES __NO
Shunt (spinal or intraventricular)	__YES __NO	Brain surgery/brain aneurysm clips	__YES __NO
Vascular access port and/or catheter	__YES __NO	History of cancer or tumors	__YES __NO
(e.g., Broviac, Port-a-Cath, Hickman)		Radiation seeds/implants/radiation/chemo	__YES __NO
Swan – Ganz or thermodilution catheter	__YES __NO	Previous spine (neck/back) surgery	__YES __NO
Aortic aneurysm surgery	__YES __NO		

I have answered these questions to the best of my knowledge and understand the information presented to me. I attest that the information is accurate to the best of my knowledge. I have read and understand the entire contents of this form and I have been given the opportunity to ask questions regarding this information and the MRI procedure.

I have elected to:  Proceed with the MRI  Decline to proceed with the MRI

\_\_\_\_\_  
Patient/Parent/Legal Guardian

\_\_\_\_\_  
Date

## MRI STAFF ONLY

I have reviewed the above patient information and determined it is  SAFE or  NOT ADVISED for patient to proceed with the MRI scan at the present time. Refer to MRI patient History and Screening Form