BAY RADIOLOGY
San Ramon

MRI Screening Questionnaire

Patient Account Number: _____

Print Name: _____ Date: _____

Gender: _____ DOB: _____ Weight: _____ Height: _____

This questionnaire is designed to assist us in determining if it is safe for you to undergo a magnetic resonance imaging procedure. It is important that you answer all of the following questions. If you don't understand any question(s), please ask for assistance.

1.	Do you have a cardiac pacemaker, implantable cardiac defibrillator, stents, or cardiac wires?	☐ Yes	☐ No	☐ Don't Know
2.	Do you have cochlear implants in your inner ear?	☐ Yes	☐ No	☐ Don't Know
3.	Do you have a history of kidney disease or are you currently on dialysis?	☐ Yes	☐ No	☐ Don't Know
4.	Have you ever had any head surgery requiring aneurysm clips?	☐ Yes	☐ No	☐ Don't Know
5.	Have you ever had any type of surgery?	☐ Yes	☐ No	☐ Don't Know
	If yes, please list: _____			
6.	Do you have any surgically implanted metal of any type in your body?	☐ Yes	☐ No	☐ Don't Know
	If yes, please list: _____			
7.	Do you have any metal pins, prosthesis or metallic object in, or attached to, your body?	☐ Yes	☐ No	☐ Don't Know
	If yes, please list: _____			
8.	Have you ever been exposed to metal fragments that could be lodged in your eyes or body?	☐ Yes	☐ No	☐ Don't Know
9.	Do you have a hearing aid, middle/inner ear prosthesis or dentures?	☐ Yes	☐ No	☐ Don't Know
10.	Do you have any type of electronic device (stimulator or pump) implanted in your body?	☐ Yes	☐ No	☐ Don't Know
11.	Do you have or have you ever had tattoos, tattooed eyeliner or lip liner, or body piercing?	☐ Yes	☐ No	☐ Don't Know
12.	Do you wear a medicine skin patch on your body (e.g., nitroglycerin, nicotine, or hormone)?	☐ Yes	☐ No	☐ Don't Know
13.	Have you ever had a reaction to a contrast agent used for MRI, CT or X-Ray?	☐ Yes	☐ No	☐ Don't Know
14.	Do you have a history of panic attacks or fear of enclosed or narrow places?	☐ Yes	☐ No	☐ Don't Know
15.	If you are a female, are you pregnant, or is it possible that you might be pregnant?	☐ Yes	☐ No	☐ Don't Know
16.	If you are a female, are you breastfeeding?	☐ Yes	☐ No	
17.	Is there any other item or device you believe we should know about prior to performing the procedure?	☐ Yes	☐ No	
	If yes, please describe: _____			

I certify that I have read and understood the questions asked in this questionnaire and that the above responses are correct to the best of my knowledge. I understand that it is my responsibility to inform the Center of any metal fragments or devices that may be in my body and that by failing to do so may cause serious bodily injury or be life threatening. I agree that should I have any metal in my body and, after consultation with a physician, elect to proceed with the MRI, I agree to release the Center from any and all liability for any injury.

Patient or Legal Representative Signature	Print Name (and Authority if Legal Representative)	Date
Witness or Interpreter Signature	Print Name	Date
Physician/Registered Nurse/Technologist Signature	Print Name and Title	Date