Beth Israel Deaconess Medical Center
Boston, MA 02215

MRI OUTPATIENT SCREENING QUESTIONNAIRE

PATIENT'S NAME ____________________
MED. REC. # ____________________
DOB ____________________
Patient Identification

Today's Date: _____/_____/_____

Patient's Name: ____________________ **Weight:** _________ **Height:** ________

An MRI involves the use of a very strong magnet. For your safety, the presence of certain metallic objects must be determined ***before*** you enter the exam room. Please place a check in the appropriate column for each item below and provide as much information as possible about any implanted devices.

	Yes	No		Yes	No
1. Pacemaker / Pacer wires / Implantable defibrillator Make / Model #:____________________ Date: ____/____/____			16. Are you wearing a patch that delivers medication?		
2. Intracranial or brain aneurysm clip (brain surgery) Make / Model #:____________________ Date: ____/____/____			17. Do you have a history of difficult IV starts?		
3. Have you had an MRI before?			18. Do you have an implanted port or indwelling catheter? Type:____________________		
If yes, did you receive a contrast injection?			19. Implanted pump (insulin, pain med, chemotherapy) Type: ____________ Location:__________		
4. Have you had an MRI in the past 7 days?			20. Are you on dialysis?		
If yes, did you receive a contrast injection?			***If yes***, how often:____________________		
5. Metallic heart valve or any metallic stents Make / Model #:____________________ Date: ____/____/____			21. Please **list** all surgeries: ____________________ ____________________ ____________________ ____________________ ____________________		
6. Bio or neurostimulator, electronic device or implant Make / Model #:____________________ Date:____/____/____					
7. Tattoo(s), Tattooed eyeliner Location: __________					
8. Body piercing ***If yes***, location(s):____________________			22. Please ***check*** if you have any of the following medical conditions: ☐ Asthma / Hay fever ☐ Heart Disease ☐ Multiple Myeloma ☐ Thyroid Disease ☐ Pheochromocytoma ☐ Sickle Cell Disease		
9. Metal injury to the eye requiring medical attention ***If yes***, date of injury:____/____/____					
10. Shrapnel (metal in body) Location:____________			**FEMALES ONLY:**	**Yes**	**No**
11. Ear surgery or prosthesis Type or Model:____________________ Date:____/____/____			23. Is there any possibility of pregnancy?		
12. Eye surgery or prosthesis Type or Model:____________________ Date:____/____/____			24. Intrauterine Device (IUD) or Diaphragm Type or Model: ____________________		
13. Limb or joint replacement or pinning Location:____________________			25. Pessary (in pelvis)		
14. Tissue expander (*e.g.* breast implant)			**MALES ONLY:**	**Yes**	**No**
15. Are you currently undergoing an endoscopy study that uses a small pill camera?			26. Do you have a penile implant? ***If yes***, make and model: ________________		

MRI Staff will speak to you about the need for removing the following items:

Removable dental work	Eyeglasses	Wallet / keys	Watch / Jewelry	Credit and ATM (Automated Machine) cards	Hearing aids	Wigs / hairpieces or bobby pins

X____________________ or **X** ____________________ and ____________________ ____/_____/____
Patient's Signature — Person authorized to sign for patient — Relationship to patient — Date

X____________________ ____________________ _____/_____/_____ ____ ____ ____ ____
Nurse or Technologist Signature — Print Name — Date — Time (24 hour)

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Boston, MA 02215

MRI OUTPATIENT SCREENING QUESTIONNAIRE

PATIENT'S NAME ______________________

MED. REC. # ______________________

DOB ______________________

Patient Identification

MR2062

Today's Date: ____/____/____

Patient's Name: ____

Questions for Contrast Administration	**Yes**	**No**
27. Have you ever been told you have renal or kidney problems?		
28. Have you ever been told you have protein in your urine?		
29. Do you have high blood pressure?		
30. Do you have diabetes?		
31. Do you have gout?		
32. Have you ever had kidney surgery?		

Allergies: ☐ No Known Allergies	**Reaction:**
33. Please **list** below all allergies to medications, food, or latex:	

Medications: ☐ None	**Last Dose**	
34. Please **list** below all prescription and over-the-counter medications you take:	**Date**	**Time**
	/ /	__ __ : __ __
	/ /	__ __ : __ __
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Discharge instructions to patient: ☐ Resume your usual medications ☐ Special instructions:____________________

____

X________________________ or X ________________________ and ____________________ _____/_____/_____
Patient's Signature — Person authorized to sign for patient — Relationship to patient — Date

X________________________ ________________________ _____/_____/_____ ___ ___ ___ ___
Nurse or Technologist Signature — Print Name — Date — Time (24 hour)

IV Site: ____________________ **IV Tech:** ____________________

Gauge: ____________________ **Scan Tech:** ____________________