



Cedar Court Imaging MRI Patient Safety Questionnaire

Patient: _____

Date: _____ MRI Exam: _____

Referring Physician: _____

Reason for Exam: _____

Have you ever had an MRI before? _____ Where: _____

When: _____ Body Part Scanned: _____

Any recent Xrays, CT scans, Ultrasounds, or Nuclear exams? _____

Please answer Yes or No to the following questions:

	Yes	No	Comments
Pacemaker	()	()	_____
Aneurysm Clips	()	()	_____
Shunts or Stents	()	()	_____
Heart Valve Replacement	()	()	_____
Heart Surgery	()	()	_____
Brain Surgery	()	()	_____
Worked with Metal			
Grinding/Welding	()	()	_____
Major Surgeries	()	()	_____
Metal Implants	()	()	_____
Neurostimulator/TENS	()	()	_____
Pregnant	()	()	_____
Breastfeeding	()	()	_____
Eye or Ear Implant	()	()	_____
Insulin Pump	()	()	_____
Penile Implant	()	()	_____
Piercings	()	()	_____
IUD	()	()	_____
Gun Shot Wound	()	()	_____
Joint Replacement	()	()	_____
Tattoo (including eyeliner)	()	()	_____
Rare Blood Disease	()	()	_____
Hearing Aid	()	()	_____
Dentures	()	()	_____
Hairpins/Jewelry	()	()	_____
Allergy to Latex	()	()	_____
Renal Disease/Compromise	()	()	_____

It is very important that you remove jewelry, watches, wallets, coins, hairpins, and any other metallic object in your pockets or on you before entering the MRI scan room. Please let the technologist know if you have any questions or concerns. The technologist will review this form with you prior to your scan.

Patient Signature _____

Date _____

Technologist Signature _____

Date _____