

# MAGNETIC RESONANCE ENVIRONMENT SCREENING QUESTIONNAIRE



This MR system has a very strong magnetic field that may be hazardous to individuals entering the magnet room if they have certain metallic, electronic, magnetic, or mechanical implants, devices or objects. Therefore, all individuals are required to fill out this form **BEFORE** entering the magnet room. Be advised, the magnet is **ALWAYS ON**.

1. Have you had prior surgery or an operation (eg. arthroscopy, endoscopy, etc) of any kind?  Yes  No  
If yes, please provide: Date(s): \_\_\_\_\_ Type(s) of surgery: \_\_\_\_\_
2. Have you had an injury to the head or eye involving a metallic object (e.g. metallic slivers, foreign body)?  Yes  No  
If yes, please describe: \_\_\_\_\_
3. Have you ever been injured by a metallic object (e.g. BB, bullet, shrapnel, welding accident, etc.)?  Yes  No  
If yes, please describe: \_\_\_\_\_
4. Are you pregnant, suspect you may be pregnant or attempting to conceive?  Yes  No
5. Have you had a previous contrast dye reaction?  Yes  No



**WARNING:** Certain implants, devices or objects may be hazardous to you in the MR environment or the magnet room. DO NOT ENTER the MR environment or the magnet room if you have any of the following implants, devices or objects.

**Please indicate if you have any of the following:**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Aneurysm clip(s)</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac pacemaker, pacemaker wires, or stents</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Implanted cardioverter defibrillator (ICD)</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Electronic or magnetically-activated implant or device (electrodes, wires, metallic filter or coil)</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Neurostimulation system, spinal cord stimulator</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Implanted or transcutaneous bio-stimulator (spinal cord, bone growth/bone fusion, tens unit, etc.)</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Cochlear, otologic, or other ear implant</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Insulin or other infusion pump</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Implanted drug infusion device</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Any type of prosthesis (heart valve, eyelid spring/wire, penile, limb, etc.)</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Shunt (spinal or intraventricular)</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Vascular access point and/or catheter</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Radiation seeds or implants</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Swan/Ganz or thermodilution catheter</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Medication patch (Nicotine, Nitroglycerine)</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Any metallic fragment or foreign body</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Wire mesh implant</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Surgical staples, clips or metallic sutures</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Joint replacement (hip, knee, etc.)</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Bone/joint pin, screw, nail, wire, plate, etc.</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Tissue expander (e.g. breast)</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes <input type="checkbox"/> No IUD, diaphragm, or pessary</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Tattoo or permanent makeup</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Body piercing jewelry</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Dentures/partial plates, dental work other than fillings (<i>Must be removed</i>)</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Hearing aid (<i>Must be removed before entering the magnet room</i>)</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No <b>Other implant</b> _____</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Breathing problem or motion disorder</li> <li><input type="checkbox"/> Yes <input type="checkbox"/> No Do you have claustrophobia?</li> </ul> |
|--|---|

**IMPORTANT INSTRUCTIONS**

**Remove all metallic objects before entering the MR environment or magnet room including:**

<input type="checkbox"/> Hearing aids	<input type="checkbox"/> Paperclips
<input type="checkbox"/> Dentures	<input type="checkbox"/> Coins
<input type="checkbox"/> Beeper	<input type="checkbox"/> Credit/Debit cards
<input type="checkbox"/> Cell phone	<input type="checkbox"/> Magnetic strip cards
<input type="checkbox"/> Keys	<input type="checkbox"/> Pens
<input type="checkbox"/> Eyeglasses	<input type="checkbox"/> Pocket knife
<input type="checkbox"/> Hair pins	<input type="checkbox"/> Nail clippers
<input type="checkbox"/> Watch	<input type="checkbox"/> Steel-toed boots/shoes
<input type="checkbox"/> Safety pins	<input type="checkbox"/> Tools
<input type="checkbox"/> Jewelry (including body piercing jewelry)	

**Loose metallic objects are especially prohibited in the magnet room and MR environment.**

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Person Completing Form: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Print Name Signature

Form Reviewed By: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Print Name Signature