Oakland MRI Center, LLC

MRI PATIENT SCREENING QUESTIONNAIRE

Name:_____

Date Of Birth_____ Weight: (Limit 350 lbs.)_____

The following information must be provided or exam may be cancelled:

☐ YES ☐ NO Pacemaker (**If yes, exam cancelled**)

☐ YES ☐ NO Brain Aneurysm Clip (**If MR safe patient must have documentation**)

☐ YES ☐ NO Stent or Filter Replacement (**date, make and model needed**)

☐ YES ☐ NO Heart Valve Replacement (**date, make and model needed**)

☐ YES ☐ NO **EVER** welded or grind with metal (**If yes, patient is to have orbit x-rays 48 hours prior to exam**)

☐ YES ☐ NO Eye Surgery or Implants (**date, make and model needed**)(**IF done before 1980 cancel exam**)

☐ YES ☐ NO Major Surgery (**Must be more than 6 weeks post-operative**)

☐ YES ☐ NO Implanted Pump/ and or a stimulator (**date, make, and model**)

☐ YES ☐ NO Brain Surgery (**PLEASE EXPLAIN**)

☐ YES ☐ NO Claustrophobia

☐ YES ☐ NO Gun Shot Wound (**PLEASE list date and location**)

☐ YES ☐ NO Body Piercing (**MUST remove**)

☐ YES ☐ NO History of Cancer?

☐ YES ☐ NO History of Seizures?

☐ YES ☐ NO Hearing Device (**PLEASE Remove**)

☐ YES ☐ NO Previous MRI (**date**)

☐ YES ☐ NO History of Renal Failure? Stage if Known?

☐ YES ☐ NO Any Tattoos (**May feel warming at site of tattoo**)

☐ YES ☐ NO Artificial Joints (**Please List**)

☐ YES ☐ NO Removable Dental Work? (**if YES, please remove**)

****Remove watches, all jewelry, credit cards and all loose metal in pockets****

Patient's Signature:_____