MR Safety Screening

Name: _____ Date of Birth: _____ Height: _____

Referring Provider: _____ Date of Exam: _____ Weight: _____

Do you have or have you ever had **ANY** of the following? Please answer **ALL** questions.

Yes No Cardiac pacemaker, defibrillator or other heart implant (***in place or removed***)

Yes No Heart prosthesis *(PFO/ASD closure device, Watchman)* or implanted cardiac recorder *(**loop recorder**)*

Yes No Neurostimulation system: Brain, spine, bladder, stomach, sleep apnea, vagus *(**in place or removed**)*

Yes No Colonoscopy, endoscopy or Pillcam endoscopy device (***within past 2 months***)

Yes No Joint replacement, pin, screw or plate ***Where?***_____.

Yes No Artificial or prosthetic limb, eye or penile implant. ***Where?*** _____.

Yes No Eye surgery: Cataract, Lens implant, glaucoma shunt, iSTENT, eyelid spring or eyelid weight ***Date***_____.

Yes No Injury to eye by metallic object or history of metal in your eyes ***When***?_____.

Yes No Any other metal foreign bodies *(Shrapnel, bullet, BB)* ***Where?*** _____.

Yes No Any other electronic or magnetically activated implants (***LINX band or other***) _____.

Yes No Aneurysm clips or embolization coils

Yes No Shunt (*Spinal or intraventricular*)

Yes No Tissue expander (*Breast expander,palate expander,other*)

Yes No Surgical staples, clips, metallic sutures

Yes No Wire mesh implant

Yes No Vascular access port

Yes No Insulin pump or other implanted drug infusion device

Yes No Cochlear, BAHA, otologic or other ear implants

Yes No Hearing aids (***must remove before entering MRI room***)

Yes No Magnetic eyelashes or eyeliner

Yes No Spray on or powdered hair/scalp coloring

Yes No Copper containing garment, socks, underwear or brace

Yes No Are you claustrophobic?

Yes No Electronic monitoring equipment *(ankle monitor, other)*

Yes No Any stent, filter, coil or graft

Yes No Internal electrodes or wires

Yes No Bone growth or electronic fusion stimulator

Yes No Radiation seeds or implants

Yes No Currently pregnant

Yes No IUD, diaphragm, pessary

Yes No Medication patch/Constant glucose monitor

Yes No Breathing problems or motion disorder

Yes No Body piercing jewelry

Yes No Any tattoo or permanent make-up

Yes No Tattooed within the past 2 days

Yes No Dentures or partial plate

Yes No Other implants not queried_____

Staff Use Only:_____

Yes No Allergic reaction to MRI contrast?

Yes No Anaphylaxis/Severe reaction to *anything*

Yes No Asthma History

Yes No Recent history of kidney failure?

Yes No Are you on dialysis treatment?

Patient Initials: _____ *I have been given a copy of a gadolinium medication guide, for my review.*

IMPORTANT!!! - For your safety, you must remove ALL metallic and electronic objects and dress into the gown provided.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the MR procedure that I am about to undergo.

Form Completed By: _____ Signature: _____

Relationship to Patient: _____ Date: _____

Staff Use Only:
Reviewed By: Staff: _____ Date: _____ Staff: _____ Date: _____

MRI Breast Questionnaire

Patient Name: _____ Date: _____

Did you give birth prior to age 30? Yes No
Do you have breast implants? Yes No
Have you had a previous mammogram? Yes No
Where? _____ When? _____
Have you had a previous breast ultrasound or breast MRI? Yes No
Where? _____ When? _____
Family History of breast Cancer Yes No
Who? _____ Age? _____

Have you received a COVID vaccine or booster in the last 90 days? Yes No Left Right (Circle)

Personal Breast History

Have you ever had a breast procedure before, biopsy, implants, lift or any other procedure where a needle has penetrated breast tissue? Please explain_____

Biopsy Right No Yes How Many? _____ **Biopsy Left** No Yes How Many? _____

Most Recent Biopsy Date: _____				Most Recent Biopsy Date: _____			
Benign	No	Yes	If Yes, Date_____	Benign	No	Yes	If Yes, Date_____
Malignant	No	Yes	If Yes, Date_____	Malignant	No	Yes	If Yes, Date_____
Mastectomy	No	Yes	If Yes, Date_____	Mastectomy	No	Yes	If Yes, Date_____
Lumpectomy	No	Yes	If Yes, Date_____	Lumpectomy	No	Yes	If Yes, Date_____
Radiation	No	Yes	If Yes, Date_____	Radiation	No	Yes	If Yes, Date_____
Chemo	No	Yes	If Yes, Date_____	Chemo	No	Yes	If Yes, Date_____
Other	No	Yes	If Yes, Date_____	Other	No	Yes	If Yes, Date_____

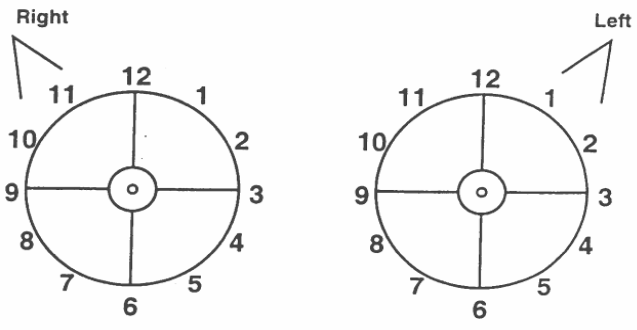
Has Your Cancer Treatment Ended? **No** **Yes** If Yes, Date_____
Taking Hormones? Yes No Date Started: _____ Date Stopped: _____
Start date of last normal menstrual cycle: _____
Taking birth control pills? Yes No If yes, how long? _____
Are you allergic to metal? Yes No

Reason for Current Examination

Follow-Up to Cancer	Right	Left
Implant rupture	Right	Left
Lump(s)	Right	Left
Pain	Right	Left
Nipple discharge (+ color)	Right	Left
Very high risk	Right	Left
Other	Right	Left

Remarks: _____

PHYSICAL EXAMINATION (for office use only)



Remarks: _____

Technologist: _____

X-Ray Facility/Year: _____