IMAGING CENTER AT CYPRESS
MRI SAFETY SCREENING FORM

Date_____
Name (first, middle, last) _____
Birth Date _____ **Age**_____ **Gender:** ☐ **Male** ☐ **Female**
Height _____ **Weight** _____

Do you have any history of cancer? If yes, what type?	☐ Yes ☐ No
Have you ever had surgery on the area being examined today? If yes, please provide date and location exam was done.	☐ Yes ☐ No
Have you ever been injured by a metallic object (BB, bullet, or shrapnel)?	☐ Yes ☐ No
Have you ever had metal removed from you eye?	☐ Yes ☐ No
Have you had an MRI since?	☐ Yes ☐ No
Do you have any allergies? Please list:	☐ Yes ☐ No
Have you ever had a reaction to the MRI or CT contrast? What type of reaction?	☐ Yes ☐ No
When was the first day of your last menstrual cycle?	☐ N/A Date:
Are you pregnant or possibly pregnant?	☐ N/A ☐ Yes ☐ No
Any history of kidney disease?	☐ Yes ☐ No
Any history of hypertension?	☐ Yes ☐ No
Any history of diabetes?	☐ Yes ☐ No

Any previous imaging on the area being scanned?

	Location	Date	Body Part
MRI			
CT/CAT SCAN			
X-ray			
Ultrasound			
Nuclear Medicine			

	YES	NO		YES	NO
Cardiac pacemaker	☐	☐	Artificial heart valve	☐	☐
Implanted cardiac defibrillator	☐	☐	Aneurysm clips	☐	☐
Electronic implant device	☐	☐	Spinal cord stimulator	☐	☐
Magnetically activated implant or device	☐	☐	Neurostimulator	☐	☐
Internal electrodes or wires	☐	☐	Wire mesh implant	☐	☐
Bone growth/bone fusion stimulator	☐	☐	Eyelid spring/weight	☐	☐
Cochlear or other ear implant or surgery	☐	☐	Dentures or partials	☐	☐
Surgical staples, clips or metallic sutures	☐	☐	Body piercings	☐	☐
Joint replacement	☐	☐	Hearing aid	☐	☐
Bone or joint pin, screw, nail, plate, etc.	☐	☐	Stent, filter or coil	☐	☐
Vascular access port and/or catheter	☐	☐	Tissue expander	☐	☐
Insulin or other infusion pump	☐	☐	Artificial or prosthetic limb	☐	☐
Continuous Glucose monitor	☐	☐	Tattoo or permanent makeup	☐	☐

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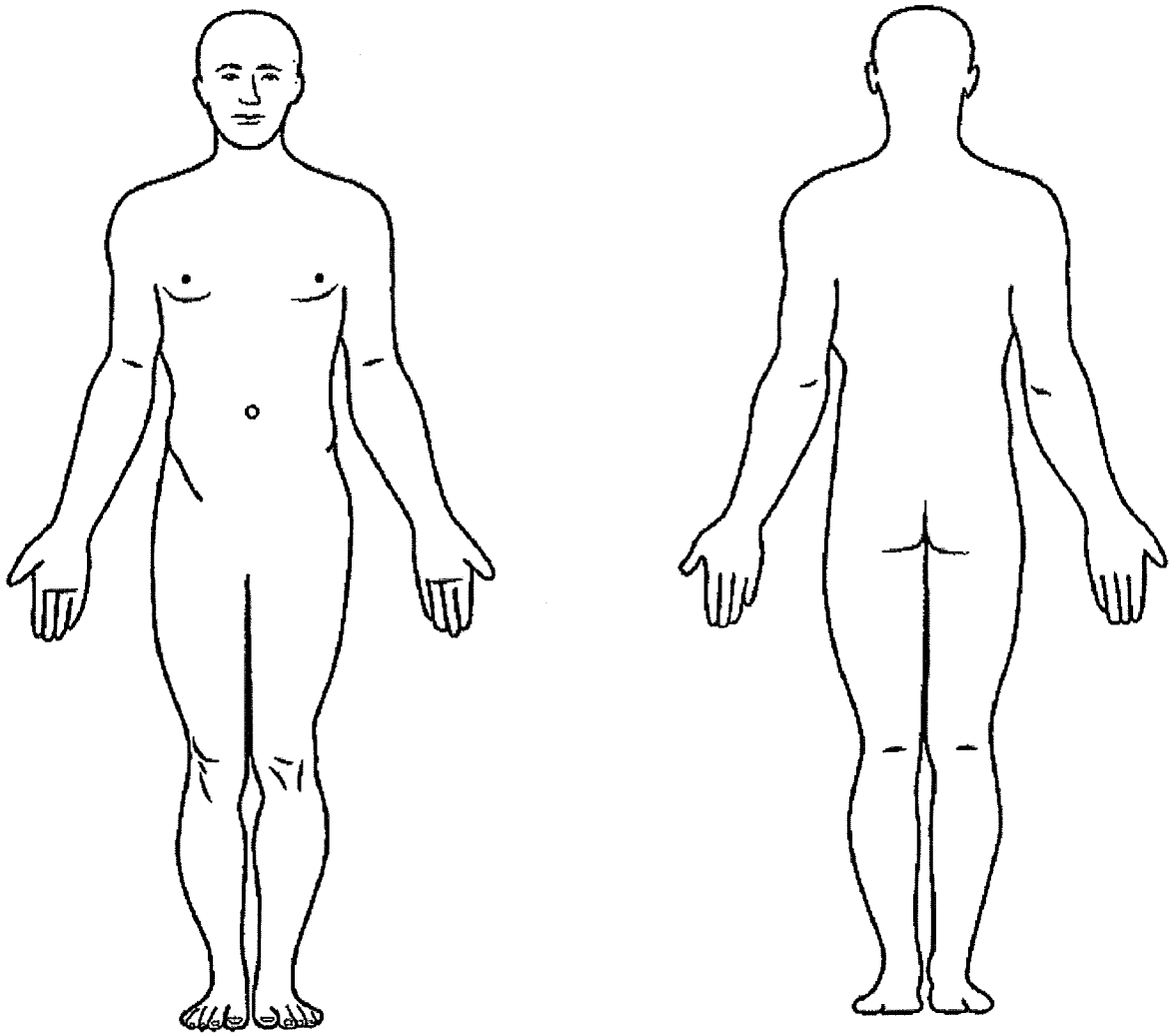
	YES	NO		YES	NO
Endoscopy small camera capsule	☐	☐	Claustrophobic	☐	☐
Shunt (spinal or intraventricular)	☐	☐	IUD, diaphragm or pessary	☐	☐
Transdermal patch (nicotine, nitroglycerine)	☐	☐	Wig, hair extensions, pins	☐	☐
Any other implants or prosthesis	☐	☐	Magnetic eyelashes	☐	☐

Please mark on the figure(s) below the location of any implants, metal, tattoos, or permanent makeup inside or on your body.



Before your MRI, please remove all metallic objects including keys, hair pins, barrettes, jewelry, watch, safety pins, paper clips, money clips, credit cards, coins, pens, belt, metal buttons, pocket knife and clothing with metal in the material.

Signature: _____ Date: _____

From completed by: ☐ Patient ☐ Relative: _____