



NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

WEIGHT: \_\_\_\_\_ lbs. \_\_\_\_\_

The following items may be harmful to you during your MRI Scan or may interfere with the MRI examination. You must provide a “**yes**” or “**no**” for every item. Please indicate if you have, or have had any of the following:

| * SIGNATURE:                                                                                                                                     | YES                      | NO                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| Any type of electronic, mechanical, or magnetic implant: ear (otologic, cochlear, or other ear implant), penile, or other<br>If yes, type: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac pacemaker, defibrillator or other cardiac implant (in place or removed)                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Aneurysm clip                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial heart valve                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurostimulator / biostimulator (e.g., spinal cord or brain stimulator)<br>If yes, type _____                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Any type of internal electrodes or wires                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing aid                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain medicine)                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Medication patch (e.g., nitroglycerin, nicotine)                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Spinal fixation device (e.g., Halo Vest)                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Spinal fusion procedure                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Any type of coil, filter, or stent<br>If yes, where and what type? _____                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Any type of metal object (e.g., shrapnel, bullet, BB, metal fragment, or foreign body)                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Bone growth / bone fusion stimulator                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Shunt (spinal or intra-ventricular)                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye surgery (e.g., eyelid springs, scleral buckle, cataracts, cornea transplant, or other eye implant)                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Any type of surgical clip or staple                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Any IV access port (e.g., Broviac, Port-a-Cath, Hickman, PICC line)                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Endoscopy or Colonoscopy in the last 30 days?<br>If yes, when? _____                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Prosthesis (artificial limb, joint, or eye)<br>If yes, location: _____                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Tissue expander (e.g., breast)                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Removable dentures, false teeth or partial plate                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Diaphragm, IUD, pessary<br>If yes, type: _____                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Surgical mesh<br>If yes, location _____                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Body piercing, including dermal (under the skin)<br>If yes, location _____                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Permanent makeup (tattoos or tattooed eyeliner)                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Radiation seeds (e.g., cancer treatment)                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Bone / joint pins, rods, screws, nails, plates, wires, spinal fusion, etc.<br>If yes, location: _____                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Tracking device (such as an ankle bracelet provided by law enforcement)                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |



TECHNOLOGIST: \_\_\_\_\_

MR99082 (11/21)