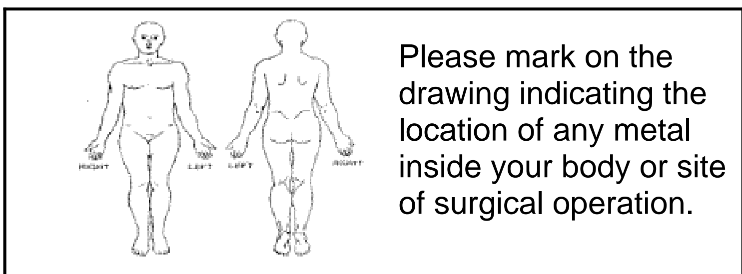
Date: ______________ Height _________ Weight _______

Have you ever had an MRI examination before and had a problem? ☐ Yes ☐ No
Are you presently taking Feraheme for Anemia? ☐ Yes ☐ No
Have you ever had a surgical operation or procedure of any kind? ☐ Yes ☐ No
Have you ever been injured by a metal object or foreign body (e.g. bullet, BB, shrapnel)? ☐ Yes ☐ No
Have you ever had an injury from a metal object in your eye
(metal slivers,shavings or other objects)? ☐ Yes ☐ No
If yes, did you seek medical attention? ☐ Yes ☐ No, describe what was found: ____________________
Do you have a history of kidney disease, asthma, or other allergic respiratory disease? ☐ Yes ☐ No
Have you ever received a contrast agent or X-ray dye used for MRI, CT, or other
X-ray or study? ☐ Yes ☐ No
Have you ever had an X-ray dye or MRI contrast agent allergic reaction? ☐ Yes ☐ No
Are you pregnant or suspect you might be pregnant? ☐ Yes ☐ No
Are you breast feeding? ☐ Yes ☐ No
If you answered yes to any of the above, please describe: ____

The following items may be harmful to you during your MRI scan or may interfere with the examination. You must provide either a "Yes" or "No" for every item.
Please indicate if you have or have had any of the following:

Any type of electronic, mechanical, or magnetic implant? ☐ Yes ☐ No
Cardiac Pacemaker* ☐ Yes ☐ No
Aneurysm clip ☐ Yes ☐ No
Implantable cardiac defibrillator* ☐ Yes ☐ No
Neurostimulator ☐ Yes ☐ No
Biostimulator ☐ Yes ☐ No
Type ____________________________
Any internal electrodes or wires ☐ Yes ☐ No
Cochlear implant ☐ Yes ☐ No
Hearing aid ☐ Yes ☐ No
Implanted drug pump ☐ Yes ☐ No
Halo vest ☐ Yes ☐ No
Spinal fixation device ☐ Yes ☐ No
Spinal fusion procedure ☐ Yes ☐ No
Any type of coil, filter, or stent ☐ Yes ☐ No
Type ____________________________
Artificial heart valve ☐ Yes ☐ No
Any type of ear implant ☐ Yes ☐ No
Type ____________________________
Any type of surgical clip or staple ☐ Yes ☐ No
Any IV access port ☐ Yes ☐ No
Medication Patch ☐ Yes ☐ No
Shunt ☐ Yes ☐ No
Artificial Eye ☐ Yes ☐ No
Eyelid spring ☐ Yes ☐ No
Insulin pump ☐ Yes ☐ No
Continuous Glucose Monitor ☐ Yes ☐ No

Implant held in place by magnet ☐ Yes ☐ No
Have you applied a Zinc ointment today? ☐ Yes ☐ No
Penile Implant ☐ Yes ☐ No
Artificial limb or joint ☐ Yes ☐ No
Where and what____________________________
Tissue expander ☐ Yes ☐ No
Removable dentures, false teeth ☐ Yes ☐ No
Diaphragm, IUD, pessary ☐ Yes ☐ No
Type ____________________________
Surgical mesh ☐ Yes ☐ No
Location ____________________________
Body Piercing ☐ Yes ☐ No
Location ____________________________
Wig, hair implants ☐ Yes ☐ No
Tattoos or tattooed eyeliner ☐ Yes ☐ No
Radiation seeds (ie cancer treatment) ☐ Yes ☐ No
Any hair accessories (bobby pins, etc..) ☐ Yes ☐ No
Jewelry ☐ Yes ☐ No
Any other type of implanted item ☐ Yes ☐ No
Type ____________________________



Please mark on the drawing indicating the location of any metal inside your body or site of surgical operation.

*If Yes, MRI - Cardiology Order form (M7630-1163) must be completed

Patient Signature: ____ Date: ________________________

250 Bon Air Road
Greenbrae, CA 94904

MRI SCREENING FORM