

**Eastern Radiology Inc. Greenville MRI  
SAFETY QUESTIONNAIRE**

MRI uses radio waves and a strong magnet to make pictures (images) of the body. Since it does not use x-rays, there are no known harmful effects to your body. However, since it does use a strong magnet, certain types of metal within the body could be attracted toward the magnet. Patients with **heart pacemakers** and **heart shocking devices** (defibrillator or ICD) must **NEVER** have an MRI exam. This safety screening form has been designed so that we can determine if it is safe for you to go near the magnet. Certain objects such as watches, credit cards, hearing aids, hair pins, keys, etc are **NOT** allowed in scan room.

If you do not understand any question listed below, or if you have any other questions about your MRI examination, please ask one of the office assistants. All your answers will be kept strictly confidential. We conform to all HIPPA regulations.

**IF YOU ANSWER YES, PLEASE ALERT OUR OFFICE ASSISTANTS**

- |  |     |    |
|--|-----|----|
| 1. Cardiac pacemaker or heart shocking device to prevent irregular heart rhythm?       | Yes | No |
| 2. Any artificial heart valves?  | Yes | No |
| 3. Heart or cardiac stents?  | Yes | No |
| When were the stents placed? _____   |     |    |
| 4. Artificial ear implants or hearing aids?  | Yes | No |
| 5. Brain aneurysm clip(s)?   | Yes | No |
| 6. Have you ever welded, filed, or ground metal, or had metal removed from your eyes.? |     |    |
| (This includes sharpening tools, lawn mower blades, etc.)                              | Yes | No |
| 7. Are you claustrophobic: uncomfortable or anxious in small spaces?                   | Yes | No |
| 8. Artificial joints, or metal joint prostheses?                                       | Yes | No |
| 9. Any recent surgery within the last eight weeks?                                     | Yes | No |
| If yes, when and what kind of surgery? Details: _____                                  |     |    |
| 10. Any bullets or shrapnel inside your body?  | Yes | No |
| 11. Have you had a nerve or bone stimulator, or infusion pump placed in your body?     | Yes | No |
| 12. Do you wear orthodontic braces, dentures or removal bridgework?                    | Yes | No |
| 13. Women: Are you pregnant or nursing, or is there a chance you could be pregnant?    | Yes | No |
| 14. Men: Do you have a penile prosthesis?  | Yes | No |
| 15. Have you ever had prior x-rays, or other radiology studies?                        | Yes | No |
| What hospital/ imaging center and the date or service? _____                           |     |    |
| 16. Are you on dialysis for kidney failure?  | Yes | No |

|  |                            |                           |
|--|----------------------------|---------------------------|
| <b>Please check any of the following that you have had or are currently being treated for.</b> |                            |                           |
| Heart Disease: _____   | High Blood Pressure: _____ | Diabetes: _____           |
| Arthritis: _____   | Bleeding Disorders: _____  | Multiple Sclerosis: _____ |
| Sickle Cell Anemia: _____  | Parkinsons Disease: _____  | HIV: _____                |
| Other: _____   |                            |                           |

I, \_\_\_\_\_ (Patient Name), acknowledge that to the best of my understanding, the above is true.

**DATE:** \_\_\_\_\_ **Signature of Patient:** \_\_\_\_\_

\*\*\*\*\*CONTINUED ON BACK\*\*\*\*\*