

Cooperative Magnetic Imaging Safety Screening Questionnaire

Patient Name _____ D.O.B. _____

- | | | |
|--|--------------|----|
| | (circle one) | |
| 1. Have you ever had surgery?..... | YES | NO |
| If yes, please list types and dates: _____ | | |
| 2. Have you had any surgical procedures in the last 6 weeks?..... | YES | NO |
| If yes, please list types & dates: _____ | | |
| 3. Have you ever worked with metal (grinding, fabrication, machine shop)..... | YES | NO |
| 4. Have you ever had any metallic objects in your eyes (slivers, foreign body, etc.) | YES | NO |
| If yes, please describe _____ | | |
| 5. Do you have any Food or Medication allergies?..... | YES | NO |
| If yes, please list _____ | | |
| 6. Are you currently undergoing Dialysis treatment?..... | YES | NO |
| 7. Are you on any Blood or Body Fluid Precautions or Infection Control Precautions?
(i.e. TB, Hepatitis, Shingles, MRSA, VRE, HIV, etc.)..... | YES | NO |
| 8. Are you Pregnant or suspect that you might be?..... | YES | NO |
| Date of your Last Menstrual Period _____ | | |
| 9. Are you currently Breastfeeding?..... | YES | NO |
| 10. Do you have any body piercings or body jewelry? (please list)_____ | YES | NO |
| 11. Have you ever had a reaction to contrast medium used for MRI or CT?..... | YES | NO |
| 12. Do you have or have you ever had a detached retina? | YES | NO |
| 13. Do you have a history of High Blood Pressure, Diabetes, Kidney or Liver Disease?..... | YES | NO |
| 14. Have you had or are you scheduled to have a liver transplant?..... | YES | NO |
| 15. Do you have a problem with the ability to stay still?..... | YES | NO |

Do you have any of the following? (circle yes or no)

- | | | | | | |
|---|-----|----|---|-----|----|
| Aneurysm Clips..... | YES | NO | Any type of implant (eye, penile, etc.)..... | YES | NO |
| Cardiac Pacemaker..... | YES | NO | Any type of prosthesis (eye, hip, etc.)..... | YES | NO |
| Cardiac Defibrillator..... | YES | NO | Any Artificial Limbs or Joint Replacements..... | YES | NO |
| Heart Valve Prosthesis..... | YES | NO | Surgical Staples, Clips or Sutures..... | YES | NO |
| Internal or Residual Pacer Wires..... | YES | NO | Bone/Joint Pins, Plates, Nails or Screws..... | YES | NO |
| ANY Stents, Filters or Coils | YES | NO | Insulin or Infusion Pump..... | YES | NO |
| ANY Shunt (spinal, intraventricular, etc.... | YES | NO | Bone Growth or Fusion Stimulator..... | YES | NO |
| Internal Electrodes or Wires..... | YES | NO | Neurostimulator..... | YES | NO |
| Vascular access port and/or catheter | YES | NO | Dentures, Braces, or Removable Dental items... | YES | NO |
| Ear implant or Hearing Aid..... | YES | NO | Medication/Skin Patch (nitro, nicoderm, ortho, etc.). | YES | NO |
| Radiation Seeds or Implants..... | YES | NO | IUD, Pessary or Diaphragm..... | YES | NO |
| Seizures..... | YES | NO | Asthma or Respiratory Disease (circle which)..... | YES | NO |
| Shrapnel, Bullets Fragments or Metal in your
body..... | YES | NO | Tattoos or Tattooed Makeup..... | YES | NO |

*******ANY "YES" answers need clarification with CMI Prior to Transfer of Services*******

* You or anyone accompanying you into the scan room will be asked to remove all metallic items such as hair pins, keys, batteries, jewelry, watches, safety pins, paperclips, money clips, credit cards, hearing aids, dentures, coins, eyeglasses, pens, belts, clothing with metal, pocket knife, pagers, cell phones, etc.

By signing below, I grant consent for the study and I attest that I understand the contents of this form; that the above information is correct to the best of my knowledge and I have had an opportunity to ask questions regarding the information on this form.

Current Weight _____ (Signature of person completing form) _____ (Date) _____

Form completed by: Patient _____ Relative or Patient Representative _____
(check one) (Print name and relationship to patient)

To be completed by CMI:
Checked in by: (front office) _____ Reviewed by (tech) _____
(Signature and date) (Signature and date)