Name:

Magnetic Resonance Imaging (MRI) Program Screening Form

Have you ever had surgery on your eyes?	☐ **Yes** ☐ **No**	*If "Yes" name any devices that were implanted:*
Have you ever had surgery on your brain?	☐ Yes ☐ No	*If "Yes" name any devices that were implanted:*
Have you ever had surgery on your ears?	☐ Yes ☐ No	*If "Yes" name any devices that were implanted:*
Have you ever had surgery on your heart?	☐ Yes ☐ No	*If "Yes" name any devices that were implanted:*
Have you ever had surgery on your abdomen?	☐ Yes ☐ No	*If "Yes" name any devices that were implanted:*
Have you ever had surgery on your spine?	☐ Yes ☐ No	*If "Yes" name any devices that were implanted:*
Do you have a pacemaker or defibrillator?	☐ Yes ☐ No	
Do you have a loop recorder?	☐ Yes ☐ No	
Do you use an insulin pump or glucose sensor?	☐ Yes ☐ No	
Do you use a drug infusion device/pump (for example, pain medication, baclofen, chemotherapy, insulin)?	☐ Yes ☐ No	
Do you have an aneurysm clip in your head?	☐ Yes ☐ No	
Do you have a deep brain stimulator?	☐ Yes ☐ No	
Do you have a vagal nerve stimulator?	☐ Yes ☐ No	
Do you have a spinal cord stimulator?	☐ Yes ☐ No	
Do you have bladder/sacral nerve simulator?	☐ Yes ☐ No	
Do you have any other stimulator?	☐ Yes ☐ No	*If "Yes" describe:*
Do you have a cochlear implant?	☐ Yes ☐ No	

Do you have auditory implants (for example, stapes implant)?	☐ Yes ☐ No	
Do you wear hearing aids?	☐ Yes ☐ No	
Do you have an endotracheal/tracheostomy tube?	☐ Yes ☐ No	
Do you have tissue expanders?	☐ Yes ☐ No	
Do you have an esophageal reflux management system LINX?	☐ Yes ☐ No	
Do you have an implanted shunt?	☐ Yes ☐ No	*If "Yes" is it programmable?*
Do you wear an artificial limb/orthopedic brace?	☐ Yes ☐ No	
Have you ever had an injury to the eye involving as metallic object?	☐ Yes ☐ No	*If "Yes" was it removed?*
Have you ever had an injury by metal object or foreign body (for example, bullet, BB, shrapnel)?	☐ Yes ☐ No	
Do you have an intrauterine device (IUD)?	☐ Yes ☐ No	
Do you have a penile implant?	☐ Yes ☐ No	