

Name:

**Magnetic Resonance Imaging (MRI)
Program Screening Form**

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

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