



MRI STUDENT MEDICAL HISTORY AND SCREENING

NAME: _____ PHONE #: _____ DATE OF BIRTH: _____
(mm/dd/yyyy)

The following items may be potentially hazardous in the Magnetic Resonance Imaging (MRI) environment. If you have any questions, please contact the MRI Program Chair. **Please indicate if you have ever had any of the following:**

SECTION 1

Yes	No
___	___
___	___
___	___
___	___
___	___
___	___
___	___
___	___
___	___
___	___
___	___
___	___

Cardiac Pacemaker / Automatic Defibrillator
Cardiac Pacing Leads/Wires
Aneurysm Clip(s)
Implanted Insulin Pump
Glucose Monitoring Device
Implanted Drug Infusion Device
Bone Growth or Neurostimulator
Tissue expanders
Middle Ear Implants (cochlea, stapes)
Intra-vascular Coils
Swan-Ganz or Thermodilution Catheter

SECTION 2

Yes	No
___	___
___	___
___	___
___	___
___	___
___	___
___	___
___	___
___	___
___	___
___	___
___	___

Hemostatic Vascular Clip(s)
Shunt (*renal, brain, heart, spine*)
Any type of surgical clip or staple(s)
Heart Valve Prosthesis
Vena Cava Filter
Penile prosthesis
Eye Prosthesis, eyelid spring or wire
Shrapnel or Bullet
Electronic/Magnetic implant or device
Surgical clips, Staples, Wire Sutures
Coils, Filters, or Stents

SECTION 3

Yes	No
___	___
___	___
___	___
___	___
___	___
___	___
___	___
___	___
___	___
___	___

IUD, diaphragm , or pessary (If yes, please specify the type: _____)
Wire Mesh Wire Mesh implant
Artificial Limb or Joint
Any orthopedic item(s) (i.e., pins, rods, screws, nails, clips, plates, wire, etc.)
Dentures or any type of removable dental item
Hearing Aid
Tattoos or permanent makeup
Body Piercings
Medication Patches (i.e., nicotine, nitroglycerine, etc.)

Have you ever had any surgical procedures or operations? _____ Yes _____ No

Type: _____ Year: _____

Type: _____ Year: _____

Type: _____ Year: _____

Have you **EVER** had an injury to your eyes with metal or had any metal fragments in your eyes? _____ Yes _____ No

If **YES**, was the metal removed by a doctor? _____ Yes _____ No

I have answered the above questions to the best of my ability.

Signature of Student

Date

* Program Chair may contact you for further clarification.