MRI STUDENT MEDICAL HISTORY AND SCREENING

NAME_____ **PHONE #**_____

The following items may be potentially hazardous in the Magnetic Resonace environment. If you have any questions please contact the MRI Program Coordinator. Please indicate if you have any of the following:

SECTION 1

Yes	No	
___	___	Cardiac Pacemaker / Automatic Defibrillator
___	___	Aneurysm Clip(s)
___	___	Implanted Insulin Pump
___	___	Implanted Drug Infusion Device
___	___	Bone Growth or Biostimulator
___	___	Neurostimulator
___	___	Epicardial Leads
___	___	Cochlear Implant
___	___	Intra-vascular Coils
___	___	Swan-Ganz Catheter

SECTION 2

Yes	No	
___	___	Hemostatic Vascular Clip(s)
___	___	Any type of surgical clip or staple(s)
___	___	Heart Valve Prosthesis
___	___	Vena Cava Filter
___	___	Middle Ear Implant
___	___	Eye Prosthesis
___	___	Shrapnel or Bullet
___	___	Magnetically operated devices
___	___	Wire Sutures
___	___	Stents

SECTION 3

Yes	No	
___	___	Diaphragm or IUD
___	___	Renal Shunt
___	___	Intraventricular Shunt
___	___	Wire Mesh
___	___	Artificial Limb or Joint
___	___	Any orthopedic item(s) (ie. pins, rods, screws, nails, clips, plates, wire, etc.)
___	___	Dentures or any type of removable dental item
___	___	Hearing Aid
___	___	Tattoos
___	___	Body Piercings
___	___	Transdermal Patches (i.e.; nicotine, nitroglycerine, etc.)

Have you ever had any surgical procedure or operation?_____Yes_____No

Type:_____Year:_____

Type:_____Year:_____

Type:_____Year:_____

Have you **EVER** had any metal fragments in your eyes, or had an injury to your eyes with metal?_____Yes_____No

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

_____ _____

Signature of Student Date