MRI Metal Screening Questionnaire: Directions – Ask patient the following questions and record their answers accordingly. Once the form is completed have patient sign and date at the bottom, and store form in their consent folder.

	Yes	No
1. Have you had prior surgery? (If yes, state type and date of surgery)		
2. Have you ever had ear surgery (cochlear implant or staples)?		
3. Do you have metal clips in your head or brain from previous surgery?		
4. Do you have a heart pacemaker or replacement valve?		
5. Have you ever been exposed to metal being welded, drilled or cut?		
6. Is there any possibility of metal/metal pieces in your eyes?		
7. Have you ever been treated for metal in your eyes?		
8. Have you ever been shot?		
9. Do you have any metal in your body (like shrapnel, bullets or implants)?		
10. Do you have a permanent tattooed eyeliner, wig or hairpiece?		
11. Do you have an infusion pump implant for taking insulin or medication?		
12. Do you have a nerve stimulator implant (TENS unit)?		
13. Do you have a false eye, especially one that is magnetic?		
14. Do you have dentures or removable dental bridges?		
15. Do you think you are claustrophobic?		
16. Do you have any trans-dermal patches (i.e. nicotine patch)?		
17. Female: Are you pregnant?		
18. Female: Do you have an IUD?		

Is there any possibility of metal, metal pieces, or metal implants in your body? Yes No

_____ _____

Participant Signature **Date**

_____ _____

Medical Personnel Signature **Date**