Midwest Imaging MRI Screening Form

Please circle **YES** if any of the following apply:

Height:_____ Weight:_____
(This is important to get the best scan possible)

Cardiac Pacemaker, Internal Pacing Wires, or Implanted Cardiac Defibrillator	YES
Aneurysm Clip(s)	YES
Neck, Eye, or Ear Surgery	YES
History of Cancer (if so what kind) _____	YES
Prosthesis (Artificial limb, eye, penile, etc.)	YES
Implanted Mechanical or Electrical Device	YES
Any implant held in place by a magnet (eye or dental)	YES
Shrapnel, Bullet, Foreign Bodies, or Metal in eyes &/or body	YES
Cardiovascular Catheter & Accessories (Swan Ganz, Etc.)	YES
Electrodes (Ex. Holter Monitor, Tens Unit, Etc.)	YES
Intravascular Stent, Coil, Filter, or Clamp	YES
Aortic Clip or Heart Valve	YES
Metal Plates,Pins,Screws, Clips, Rods or Joint Replacement	YES
Shunt	YES
Vascular Access Port, Infusion Pump, or Catheter (Ex. Groshung, Foley)	YES
Renal Disease/ Currently on dialysis	YES
Any chance of pregnancy	YES

Claustrophobic? Mildly Moderately Severely Not Applicable

Signature of Patient/
Guardian/Next of Kin:_____Date_____

Revised 1/12