Cleveland Clinic
Imaging Institute

MRI Screening Questionnaire

Name _____ MRN _____

DOB _____ ☐ Male ☐ Female ☐ _____ Height _____ Weight _____

		Comments	
Have you had an MRI before?	☐ Yes		☐ No
Did you have any complications with the MRI?	☐ Yes		☐ No
Have you ever had an allergic reaction to MRI contrast?	☐ Yes		☐ No
Is there any chance you could be pregnant?	☐ Yes		☐ No
Have you had a prior injury by a metal object to any body part?	☐ Yes		☐ No
Was the metal object medically removed?			

Please circle any personal items and implants you may have:

Hair pins/wig* Piercings* Loop recorder

Screws/Plates/Pins Spinal Rods/Hardware Artificial joint Eye Implant

Are you currently on dialysis?	☐ Yes		☐ No

Please mark any of the following items/implants you currently have:

☐	Hearing aid*	☐	IV access port
☐	Medication patch*	☐	Aneurysm clips
☐	Insulin pump*	☐	Coils
☐	Continuous Glucose Monitor*	☐	Filters
☐	Pacemaker or Defibrillator	☐	Stents (other than heart)
☐	Stimulator(e.g. DBS, VNS, SCS, bladder)	☐	IUD
☐	Pain or baclofen pump	☐	Penile implant
☐	Ear/cochlear implants	☐	None
☐	Tissue expanders (doesn't include breast implants)	add'l info:	
☐	Programmable shunt		

*These items must be removed prior to your MRI to prevent damage to the item and/or harm to you.

☐ I acknowledge that I will remove these items prior to my MRI.

Signature of Patient/Guardian/Relative/Clinical Service

X_____ Date_____ Time ___ : ____

If patient/family member unavailable, requesting staff shall sign above & document in the paper/digital chart that no family member is available; above screening was completed by the requesting service. Based upon reasonable review, the benefits of the MRI exam outweigh the risks.

Reviewed by Radiology MD/RN/RT_____ Printed Name_____ Date_____ Time____: ____