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
Have you had a prior injury by a metal object to any body part?	☐ Yes		☐ No
Was the metal object medically removed?	☐ Yes		☐ No

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*_____*:*_____

Revised 6/1/2023