EASTERN RADIOLOGISTS
GREENVILLE MRI

2101 W Arlington Blvd, Suite 110, Greenville, NC 27834
Mon–Fri 7am–9pm • Sat / Sun 8am–8pm
252.752.5000 | easternrad.com

Patient Name _____ DOB ___ /___ /___ Date ___ /___ /___ MRN _____

QUESTIONNAIRE: SAFETY

MRI uses radio waves and a strong magnet to make pictures (images) of the body. Since it does not use x-rays, there are no known harmful effects to your body. However, since it does use a strong magnet, certain types of metal within the body could be attracted toward the magnet. Patients with **heart pacemakers** and **heart shocking devices** (defibrillator or ICD) must NEVER have an MRI exam. This safety screening form has been designed so that we can determine if it is safe for you to go near the magnet. Certain objects such as watches, credit cards, hearing aids, hair pins, keys, etc are **NOT** allowed in scan room.
If you do not understand any question listed below, or if you have any other questions about your MRI examination, please ask one of the office assistants. All your answers will be kept strictly confidential. We conform to all HIPPA regulations.

IF YOU ANSWER YES, PLEASE ALERT OUR OFFICE ASSISTANTS

1. Cardiac pacemaker or heart shocking device to prevent irregular heart rhythm? YES NO
2. Any artificial heart valves? YES NO
3. Heart or cardiac stents? YES NO
   When were the stents placed? _____
4. Artificial ear implants or hearing aids? YES NO
5. Brain aneurysm clip(s)? YES NO
6. Have you ever sought medical treatment for getting metal fragments in your eyes or had significant exposure to welding, grinding, or smoldering due to your profession or hobby? YES NO
7. Are you claustrophobic: uncomfortable or anxious in small spaces? YES NO
8. Artificial joints, or metal joint prostheses? YES NO
9. Any recent surgery within the last eight weeks? YES NO
   If yes, when and what kind of surgery? Details: _____
10. Any bullets or shrapnel inside your body? YES NO
11. Have you had a nerve or bone stimulator, or infusion pump placed in your body? YES NO
12. Do you wear orthodontic braces, dentures or removal bridgework? YES NO
13. Women: Are you pregnant or nursing, or is there a chance you could be pregnant? YES NO
14. Men: Do you have a penile prosthesis? YES NO
15. Have you ever had prior x-rays, or other radiology studies? YES NO
    What hospital/ imaging center and the date or service?_____
16. Are you on dialysis for kidney failure? YES NO
17. Please check any of the following that you have had or are currently being treated for.

Heart Disease	_____	High Blood Pressure	_____	Diabetes	_____
Arthritis	_____	Bleeding Disorders	_____	Multiple Sclerosis	_____
Sickle Cell Anemia	_____	Parkinsons Disease	_____	HIV	_____

Other _____

I, (Patient Name), acknowledge that to the best of my understanding, the above is true.

Patient Signature _____ Technologists _____