Dartmouth-Hitchcock
One Medical Center Drive
Lebanon, NH 03756

MRI Safety and Scheduling Questionnaire

Patient Name	
Patient MRN	
Patient DOB	

Date: ___________________ Patient's Weight: _______________
Patient's Age: ____________

Do you have a Spinal cord stimulator?	Yes	No
Do you have a Defibrillator?	Yes	No
Do you have a Pacemaker?	Yes	No
Do you have Retained cardiac leads from a pacemaker or defibrillator?	Yes	No
Do you have a Deep brain stimulator?	Yes	No

Do you have a Cerebral aneurysm clip?	Yes	No
Do you have a Cochlear/other ear implant?	Yes	No
Do you have a Vagus nerve stimulator?	Yes	No
Do you have an Internal Loop Recorder (ILR)?	Yes	No
Do you have any other implanted devices or metal hardware including breast expanders, pins, plates, screws, rods, wire, etc.?	Yes	No

If yes to any of the above questions, please indicate make and model #:_________________________________

Have you ever worked with metal or have metal fragments in your eyes?	Yes	No
Have you been injured by a metal object e.g. shrapnel, bullet, BB gun?	Yes	No
Do you have body piercings?	Yes	No
Are you claustrophobic?	Yes	No
Have you ever required sedation or anesthesia for an MRI?	Yes	No
If yes, please select one: __ Oral __ IV __ Anesthesia		

Do you have or are you being treated for diabetes? (patients ≥ 50 years)*****	Yes	No
Do you have a history of kidney failure?*****	Yes	No
Are you 70 years or older?*****	Yes	No
Are you on dialysis?	Yes	No
Could you be or are you pregnant? (females between 8 and 56 years)	Yes	No
Have you had a prior reaction to the injection of MRI IV contrast?	Yes	No
If yes, please describe ____________________________		

***For YES answer to these questions, a creatinine within 90days of the scheduled exam is needed.**
Most recent creatinine on file: ________ Date of creatinine: ____________

Do you have a Mediport? __ Yes __ No

Do you have any difficulty breathing or pain while lying flat? __ Yes __ No

Do you have any mobility concerns? __ Yes __ No. If yes, please describe: ____________________________

Are you coming from a skilled care facility? __ Yes __ No
If yes, you must be accompanied by a caregiver for the entire exam or transportation arrangements made in advance.

Breast MRI Only
Bra Cup Size: ______ LMP: ____ Current BCT/HRT: __ Yes __ No

Last mammogram date: _________ Last mammogram location: ___________

Form Completed By: ______________________________ Date: _____________