SDMI STEINBERG DIAGNOSTIC

INTAKE QUESTIONNAIRE MRI

First Name _____ Last Name _____ Age _____

Height _____ Weight _____ Patient #: _____

Do you have *(Circle Yes or No for all)*:

Pacemaker / Wires / Cardiac Defibrillator	**YES**	**NO**	**If yes, Brand?** _____
Brain Aneurysm Clips	**YES**	**NO**	
Brain Aneurysm Coils	**YES**	**NO**	
Neurostimulator / Wires	**YES**	**NO**	**If yes, Where?** _____ **Brand?** _____
Bone Stimulator / Wires	**YES**	**NO**	**If yes, Where?** _____ **Brand?** _____
Cochlear Implant / Ear Implant	**YES**	**NO**	
Breast Tissue Expander	**YES**	**NO**	
Metallic Foreign Body in Eye	**YES**	**NO**	
Bullets / Shrapnel	**YES**	**NO**	**If yes, Where?** _____

If you answered YES to any of the above, please verbally notify the tech before your exam.

Drug Infusion Pump	**YES**	**NO**	
Continuous Glucose Monitor	**YES**	**NO**	**(ex: Dexcom)**
Colonoscopy or Endoscopy in the last 2 months	**YES**	**NO**	**If yes, were clips placed? YES NO**
Implantable Cardiac Monitor / Loop Recorder	**YES**	**NO**	**If yes, Brand?** _____
Linx Reflux Management Device	**YES**	**NO**	**If yes, Implant Date:** _____
Programmable Shunt Valve	**YES**	**NO**	
Medication Patch	**YES**	**NO**	**If yes, Where?** _____
Hearing Aid	**YES**	**NO**	**If yes, you must leave outside of the room.**
Tattoos or Permanent Makeup	**YES**	**NO**	**If yes, Where?** _____
			Most Recent Date: _____
Surgically implanted metal in bone (joint, rod, screws, etc)	**YES**	**NO**	**If yes, Where?** _____
Coronary artery or vascular stents/filters	**YES**	**NO**	
Heart Valve replacement	**YES**	**NO**	
Non-programmable shunt valve	**YES**	**NO**	
Dental Hardware (implants, braces, retainer)	**YES**	**NO**	
Any metal in your body not already mentioned	**YES**	**NO**	**If yes, Explain:** _____

Have you had MRI Dye in the last 24 hours	**YES**	**NO**	
Are you pregnant	**YES**	**NO**	
Have you had Iron infusion in the last 4 weeks	**YES**	**NO**	
Are you currently on Dialysis	**YES**	**NO**	**If yes, next appointment:** _____

List medication allergies/reaction(s) _____

I agree that the above information is correct *(Do not fill out until after technologist has reviewed):*

Patient Signature: _____ Todays Date: _____