COLUMBIA | RADIOLOGY

NewYork-Presbyterian

MRI Screening Form Questions

Name: _____ Date of Exam: _____

Date of Birth: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

Please inform us if it is your preference to have a chaperone in the room during your exam. ☐ I acknowledge

1.	**Reason for MRI and/or symptoms?** _____	
2.	**Have you had any related imaging studies (MRI, CT, Ultrasound, X-Ray) outside of NYPH - Cornell - Columbia?** If yes, please specify the type of imaging, date performed, and location: _____ _____	☐ YES ☐ NO
3.	**Have you had a biopsy or surgery outside of NYPH - Cornell - Columbia?** If yes, please list all surgical procedures and dates: _____ _____	☐ YES ☐ NO
4.	**Do you have a history of renal (kidney) disease or kidney surgery?** If yes, are you on dialysis: ☐ YES ☐ NO	☐ YES ☐ NO
5.	**Have you ever had an injection of MRI contrast?**	☐ YES ☐ NO
6.	**Have you ever fainted/collapsed following MRI contrast?**	☐ YES ☐ NO
7.	**Have you ever had hives following MRI contrast?**	☐ YES ☐ NO
8.	**Have you ever had shortness of breath following MRI contrast?**	☐ YES ☐ NO
9.	**Do you have claustrophobia?** If yes, have you taken medication for claustrophobia before previous MRIs or do you plan on taking it before today's MRI? ☐ YES ☐ NO	☐ YES ☐ NO
10.	**Please list any oral medications you have taken today (including any medication for anxiety or claustrophobia, iron supplements):** _____	
11.	**Please check YES or NO in the boxes below if you have any of the following:**	

Artificial heart valve	☐ YES	☐ NO	**Bone/joint pin, screw, nail, wire, plate**	☐ YES	☐ NO
Cardiac pacemaker or pacing wires	☐ YES	☐ NO	**Cochlear, otologic or other ear implant**	☐ YES	☐ NO
External Cardiac monitor or wiring	☐ YES	☐ NO	**Dentures or braces**	☐ YES	☐ NO
Implanted cardioverter defibrillator (ICD)	☐ YES	☐ NO	**Foreign body, or bullets** (e.g., BB, Shrapnel)	☐ YES	☐ NO
Loop recorder or Swan-ganz	☐ YES	☐ NO	**Implanted drug infusion device**	☐ YES	☐ NO
Nerve Stimulator or Other Stimulator? If yes, please provide the name or model number of the implant: _____ Please specify what type of stimulator: _____	☐ YES	☐ NO	**Metallic Fragments**	☐ YES	☐ NO
Catheter or feeding tube	☐ YES	☐ NO	**Prosthesis** (eye, penile, limb, etc.)	☐ YES	☐ NO

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Radiation seeds	☐ YES	☐ NO	**Surgical clips, staples, metallic sutures, or wire mesh**	☐ YES	☐ NO
Medication patch (Nicotine, Nitroglycerine)	☐ YES	☐ NO	**Tissue Expander in the breast**	☐ YES	☐ NO
Port in the arm, chest, or elsewhere on the body	☐ YES	☐ NO	**Glucose monitor and/or insulin pump/ medication pump**? If yes, name or model of device: _____	☐ YES	☐ NO
IUD, diaphragm, or pessary	☐ YES	☐ NO	**Injury to the eye(s) or implants/fragments in the eye**	☐ YES	☐ NO
Hearing Aid (remove before entering room)	☐ YES	☐ NO	**Eyelid weight, spring, or wire**	☐ YES	☐ NO
Programmable shunt	☐ YES	☐ NO	**Metallic object/fragment in the eye**	☐ YES	☐ NO
On-body injector (e.g. Neulasta)	☐ YES	☐ NO	**Scleral Buckle**	☐ YES	☐ NO
Implants in the breast (tissue expanders, saline, or silicone)	☐ YES	☐ NO	**Any other metallic object, implants, or fragments?** If yes, type/date of implant: _____	☐ YES	☐ NO
Hair Extensions, tattoos, permanent makeup, or body piercing jewelry	☐ YES	☐ NO	**Do you have a history or cancer?** What type of cancer? _____	☐ YES	☐ NO
Stent or Coil Date implant was placed: _____	☐ YES	☐ NO	**Breathing problem or motion disorder**	☐ YES	☐ NO
Breathing problem or motion disorder	☐ YES	☐ NO			

Female Patients:

12.	**Is there any possibility that you are pregnant?**	☐ YES	☐ NO
13.	**Date of your last menstrual period:** _____		
14.	**Are you breastfeeding?**	☐ YES	☐ NO

I authorize Columbia Radiology and NewYork-Presbyterian, its physicians and other staff to perform the prescribed examination.

Signature of Patient (Parent or Guardian): _____ Date: _____

If you are taking an oral anti-anxiety medication for claustrophobia, we recommend having a visitor accompany you to your appointment or arrange for transportation home. Our practice recommends this out of an abundance of caution and concern for your safety as potential side effects of these medications may affect your ability to drive or navigate public transportation. If you do not have safe transportation home, our staff may ask you to remain on site until the side effects of the medication have worn off and they feel it is safe to discharge you from our practice.

(Office use)

Technologist: _____ Signature: _____