





NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

The following items may be harmful to you during your MRI Scan or may interfere with the MRI examination. You must provide a “yes” or “no” for every item. Please indicate if you have, or have had any of the following:

	YES	NO
Any type of electronic, mechanical, or magnetic implant: eye, ear (otologic, cochlear, or other ear implant), penile, or other If yes, type: _____	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm clip	<input type="checkbox"/>	<input type="checkbox"/>
Implanted cardiac defibrillator (ICD)	<input type="checkbox"/>	<input type="checkbox"/>
Neurostimulator / biostimulator (e.g., spinal cord or brain stimulator) If yes, type _____	<input type="checkbox"/>	<input type="checkbox"/>
Any type of internal electrodes or wires	<input type="checkbox"/>	<input type="checkbox"/>
Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>
Implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain medicine)	<input type="checkbox"/>	<input type="checkbox"/>
Halo vest	<input type="checkbox"/>	<input type="checkbox"/>
Spinal fixation device	<input type="checkbox"/>	<input type="checkbox"/>
Spinal fusion procedure	<input type="checkbox"/>	<input type="checkbox"/>
Any type of coil, filter, or stent If yes, where and what type? _____	<input type="checkbox"/>	<input type="checkbox"/>
Any type of metal object (e.g., shrapnel, bullet, BB, metal fragment, or foreign body)	<input type="checkbox"/>	<input type="checkbox"/>
Bone growth / bone fusion stimulator	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>
Eyelid spring	<input type="checkbox"/>	<input type="checkbox"/>
Any type of surgical clip or staple	<input type="checkbox"/>	<input type="checkbox"/>
Any IV access port (e.g., Broviac, Port-a-Cath, Hickman, PICC line)	<input type="checkbox"/>	<input type="checkbox"/>
Medication patch (e.g., nitroglycerin, nicotine)	<input type="checkbox"/>	<input type="checkbox"/>
Shunt (spinal or intraventricular)	<input type="checkbox"/>	<input type="checkbox"/>
Prosthesis (artificial limb, joint, or eye) If yes, location: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tissue expander (e.g., breast)	<input type="checkbox"/>	<input type="checkbox"/>
Removable dentures, false teeth or partial plate	<input type="checkbox"/>	<input type="checkbox"/>
Diaphragm, IUD, pessary If yes, type: _____	<input type="checkbox"/>	<input type="checkbox"/>
Surgical mesh If yes, location _____	<input type="checkbox"/>	<input type="checkbox"/>
Body piercing, including dermal (under the skin) If yes, location _____	<input type="checkbox"/>	<input type="checkbox"/>
Permanent makeup (tattoos or tattooed eyeliner)	<input type="checkbox"/>	<input type="checkbox"/>
Radiation seeds (e.g., cancer treatment)	<input type="checkbox"/>	<input type="checkbox"/>
Bone / joint pins, rods, screws, nails, plates, wires, etc. If yes, location: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tracking device (such as an ankle bracelet provided by law enforcement)	<input type="checkbox"/>	<input type="checkbox"/>



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