Advanced Imaging Research Center
MRI Subject Screening Questionnaire

Subject Name:_____ Date:_____

Sex:_____ Age:_____ Weight_____ Subject Number:_____ IRB#: _____

This questionnaire is designed to assist us in determining if it is safe for you to undergo a magnetic resonance imaging procedure. It is important that you answer all of the following questions. **If you don't understand any question, please ask for assistance.**

1. Do you have a pacemaker, wires, defibrillator, or implanted heart valves? Yes ☐ No ☐ Don't Know ☐
2. Have you ever had any head surgery requiring aneurysm clips? Yes ☐ No ☐ Don't Know ☐
3. Have you ever had any type of surgery? Yes ☐ No ☐ Don't Know ☐
4. Have you ever had a reaction to a contrast agent used for MRI, CT or X-ray? Yes ☐ No ☐ Don't Know ☐
5. Do you have any surgically implanted metal of any type in your body? Yes ☐ No ☐ Don't Know ☐
6. Have you ever been exposed to metal fragments that could be lodged in your eyes or body? Yes ☐ No ☐ Don't Know ☐
7. Do you have a hearing aid, middle/inner ear prosthesis or dentures? Yes ☐ No ☐ Don't Know ☐
8. Do you have any metal pin, joint, prosthesis or metallic objects in, or attached to, your body? Yes ☐ No ☐ Don't Know ☐
9. Do you have any type of electric device (stimulator or pump) implanted in your body? Yes ☐ No ☐ Don't Know ☐
10. Do you have or have you ever had tattoos, tattooed eyeliner, lip liner, or body piercing? Yes ☐ No ☐ Don't Know ☐
11. Do you wear a transdermal patch (nitroglycerin or nicotine)? Yes ☐ No ☐ Don't Know ☐
12. Do you have a history of panic attacks or a fear of enclosed or narrow places? Yes ☐ No ☐ Don't Know ☐
13. Do you have a history of drug or food allergies? Yes ☐ No ☐ Don't Know ☐
14. Do you have a history of renal disease, seizure, asthma, or emphysema? Yes ☐ No ☐ Don't Know ☐
15. If you are a woman- are you pregnant, or is it possible that you might be pregnant? Yes ☐ No ☐ Don't Know ☐
16. If you are a woman- are you breastfeeding? Yes ☐ No ☐ Don't Know ☐
17. Is there any other item or device you believe we should know about prior to performing the procedure- if yes, please describe:

_____

I certify that I have read and understood the questions asked in this questionnaire and that the above responses are correct to the best of my knowledge. I understand that it is my responsibility to inform OHSU staff of any metal fragments and/or devices that may be in my body and that by failing to do so may cause serious bodily injury or be life threatening.

Patient or Legal Representative Signature	Print Name and Authority (if legal representative)	Date
Witness or Interpreter Signature	Print Name	Date

I have reviewed the MRI screen form with the subject and have determined that it is safe for him/her to proceed with the MR study as outlined in the consent.

Principal Investigator/Physician/Registered Nurse	Print Name and Title	Date