

Great Neck Standup MRI
MRI PRE-SCREENING

Patient Name _____ Age _____ Sex _____ Weight _____ DOB _____

Please answer **YES** or **NO** as to whether the following apply to you:

Cardiac Pacemaker _____ Y _____ N

Implanted Cardiac Defibrillator _____ Y _____ N

Implanted Neurostimulator _____ Y _____ N

Implanted Drug Infusion Pump _____ Y _____ N

Aneurysm Clips _____ Y _____ N

Spinal Stimulator Device _____ Y _____ N

Cochlear Implants _____ Y _____ N

Penile Implant _____ Y _____ N

IUD _____ Y _____ N

Heart Valve Prosthesis _____ Y _____ N

Artificial Limbs or Joints _____ Y _____ N

Tattooed Eyeliner or Eyebrows _____ Y _____ N

Body Piercing (other than ears) _____ Y _____ N

Other Implants in Head _____ Y _____ N

Shunt _____ Y _____ N **If Yes, Programmable?** _____ Y _____ N

Stent _____ Y _____ N

Harrington Rods _____ Y _____ N

Metal Screws or Plates _____ Y _____ N

Dentures _____ Y _____ N

Wires, Sutures or Staples _____ Y _____ N

Shrapnel or Bullets _____ Y _____ N

Coils or Filters _____ Y _____ N

Foreign Body in Eye _____ Y _____ N

Hearing Aid _____ Y _____ N

Is there any possibility that you may be pregnant _____ Y _____ N **Initials:** _____

Symptoms/Complaint: _____

Signature: _____ **Date:** _____

