Weill Cornell Imaging

NewYork-Presbyterian Weill Cornell Medicine

MRI Screening Form Questions

Name: _____ Date of Exam: _____

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

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? (**Do you get nervous or anxious in closed spaces)? 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:**	

Have you ever had cardiac (heart) implants, devices, or surgery?	☐ YES	☐ NO	**Bone/joint pin, screw, nail, wire, plate**	☐ YES	☐ NO
Artificial heart valve	☐ YES	☐ NO	**Cochlear, otologic or other ear implant**	☐ YES	☐ NO
Cardiac pacemaker	☐ YES	☐ NO	**Dentures or braces**	☐ YES	☐ NO
External cardiac monitor or wiring	☐ YES	☐ NO	**Foreign body, or bullets** (e.g., BB, Shrapnel)	☐ YES	☐ NO
Implanted cardioverter defibrillator (ICD)	☐ YES	☐ NO	**Implanted drug infusion device**	☐ YES	☐ NO
Pacing wires	☐ YES	☐ NO	**Metallic fragments**	☐ YES	☐ NO
Loop recorder	☐ YES	☐ NO	**Prosthesis** (eye, penile, limb, etc.)	☐ YES	☐ NO
Swan-ganz	☐ YES	☐ NO	**Surgical clips, staples, or metallic sutures**	☐ YES	☐ NO
Other heart implants or devices?	☐ YES	☐ NO	**Tissue expander in the breast**	☐ YES	☐ NO
If other, please describe: _____ _____			**Wire Mesh**	☐ YES	☐ NO

Nerve Stimulator If yes, please provide the name or model number of the implant: _____ _____	☐ YES	☐ NO	**Other Stimulator** If yes, type of stimulator: _____ _____	☐ YES	☐ NO
Catheter or feeding tube	☐ YES	☐ NO	**Stent or Coil** Date implant was placed: _____	☐ YES	☐ NO
Radiation seeds	☐ YES	☐ NO	**Aneurysm clips?** Approximate year it was placed: _____	☐ YES	☐ NO
Medication patch (Nicotine, Nitroglycerine)	☐ YES	☐ NO	**Breathing problem or motion disorder**	☐ 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	**Capsule endoscopy**	☐ 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 of cancer?** What type of cancer? _____	☐ YES	☐ NO

<u>Female Patients</u>:

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 Weill Cornell Imaging at 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)

Front Desk Staff: _____ Signature: _____

Technologist: _____Signature: _____

Nurse: _____ Signature: _____