

**M I N N E A P O L I S**  
**O R T H O P A E D I C S**  
 Advanced skills and experience for the results you deserve

MRI SCREENING SHEET

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*Please indicate if you have any of the following:*

	Yes	No		Yes	No
Cardiac Pacemakers	<input type="checkbox"/>	<input type="checkbox"/>	Sheet Metal Worker	<input type="checkbox"/>	<input type="checkbox"/>
Brain/Abdomen Aneurysm clips	<input type="checkbox"/>	<input type="checkbox"/>	Carotid(neck) Clips	<input type="checkbox"/>	<input type="checkbox"/>
Aortic Clips	<input type="checkbox"/>	<input type="checkbox"/>	Ear Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Implanted neurotransmitter	<input type="checkbox"/>	<input type="checkbox"/>	Heart valve replaced	<input type="checkbox"/>	<input type="checkbox"/>
Insulin pump	<input type="checkbox"/>	<input type="checkbox"/>	Heart Bypass	<input type="checkbox"/>	<input type="checkbox"/>
Hearing aids	<input type="checkbox"/>	<input type="checkbox"/>	Neurostimulators	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	Electrodes	<input type="checkbox"/>	<input type="checkbox"/>
Fractured bones treated w/metal rods			Permanent Eyeliner	<input type="checkbox"/>	<input type="checkbox"/>
Plates, screws, nails or clips	<input type="checkbox"/>	<input type="checkbox"/>	Temp. Breast Implant	<input type="checkbox"/>	<input type="checkbox"/>
Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	IUD	<input type="checkbox"/>	<input type="checkbox"/>
Metal slivers in eyes	<input type="checkbox"/>	<input type="checkbox"/>	Shunt	<input type="checkbox"/>	<input type="checkbox"/>
Cochlear implants	<input type="checkbox"/>	<input type="checkbox"/>	Harrington Rod	<input type="checkbox"/>	<input type="checkbox"/>
Shrapnel	<input type="checkbox"/>	<input type="checkbox"/>	Wire Sutures	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic	<input type="checkbox"/>	<input type="checkbox"/>
Penile, Breast or Eye Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	Breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Implant Device	<input type="checkbox"/>	<input type="checkbox"/>	Metal Mesh	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an MRI before	<input type="checkbox"/>	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	<input type="checkbox"/>

If so, where and when? \_\_\_\_\_

Other: \_\_\_\_\_

**NOTE:**

*Ensure that the following items are removed before scanning:*

- Purse, wallet or money clip
- Jewelry (for wrist and hand exams)
- Watch, keys or pocket knife
- Credit cards and bank cards with magnetic strip

List all major surgeries: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_