



# IMAGING

## CT-MRI-ULTRASOUND

### Pre-Imaging Screening Form

Division Cleveland Clinic e-Radiology

**Please print and use blue or black ink to complete this form. Bring the completed form to your Imaging appointment.**

Date of Exam: \_\_\_\_\_

Patient's full name: \_\_\_\_\_  
Please Print

Patient date of birth: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex \_\_\_\_\_

Have you previously had an MRI or CT scan performed?

Yes No Unsure (please circle)  
Date and Body part: \_\_\_\_\_

**Are you 70 years of age or older?** Yes No

**Do you have Congestive Heart Failure?** Yes No

**Are you diabetic?** Yes No

**Do you have Multiple Myeloma or Sickle Cell Disease?** Yes No

**Have you ever had kidney/renal surgery?** Yes No

**Are you on dialysis?** Yes No

**Have you ever been diagnosed with kidney disease?** Yes No

Have you ever worked in an environment where metal slivers could have penetrated or come into contact with your eyes or skin?

Yes No Unsure (Please circle.)

Have you undergone any of the following: (Please circle.)

Back Surgery	Yes	No	Unsure
Neck surgery	Yes	No	Unsure
Heart surgery	Yes	No	Unsure
Chest surgery	Yes	No	Unsure
Brain surgery	Yes	No	Unsure
Ear surgery	Yes	No	Unsure
Colonoscopy/Endoscopy	Yes	No	_____
			Date

During the course of a surgery/medical procedure has an implant ever been used? Yes No Unsure (Please circle)

Other Surgery: Date/Type

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any of the following? (Please circle.)

An incorrect answer may put you at risk of an injury.

Yes No Unsure Pacemaker/Model: \_\_\_\_\_

Yes No Unsure Aneurysm clips

Yes No Unsure AAA Graft/Model: \_\_\_\_\_

Yes No Unsure Implanted cardiac defibrillator

Yes No Unsure Artificial heart valve

Yes No Unsure Vena Cava Filter

Yes No Unsure Electrodes

Yes No Unsure Hearing Aids

Yes No Unsure Tattoos within last month

Yes No Unsure Pregnant/Possibility of pregnancy

Yes No Unsure Currently breast feeding

Yes No Unsure Shunts/Stents

Yes No Unsure Joint replacements

Yes No Unsure Bone or joint pins

Yes No Unsure Fractured bones supported by metal rods, plates, pins, screws, nails or clips

Yes No Unsure Prosthesis

Yes No Unsure Wire sutures

Yes No Unsure Shrapnel

Yes No Unsure Allergy to iodine/x-ray dye

Yes No Unsure Are you wearing any medicine patches?

**If you have any jewelry on your feet or arms please remove. Please remove all metal objects from your pockets and your person (keys, belt/buckle).**

MRI is simple, safe, and painless. However, because we use strong magnets during the procedure, metal objects in or on your body may pose a safety hazard to you or others in the MRI exam room, cause interference on the MRI images or heat up causing discomfort and possibly burns. Please carefully review the above information for accuracy and completeness.

I have reviewed the answers to the clinical screening questions above. They are true, correct, and complete to the best of my knowledge.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Technologist Signature