Scott Goldman, M.D.

Orthopedic Surgery • Sports Medicine

Name:	**Height: _________ Weight: ________**

Because of the presence of a strong magnetic field, the following questions will help us determine your safety in the MRI scanner. Please answer each question carefully.

Yes	No		Yes	No		Yes	No	
☐	☐	**Aneurysm clips or coils**	☐	☐	**Implanted medication pump**	☐	☐	**Artificial limb**
☐	☐	**Cardiac pacemaker, wires or internal defibrillator**	☐	☐	**Medication/nicotine patch**	☐	☐	**Seizures**
			☐	☐	**Dentures/implant held in place by a magnet**	☐	☐	**Orthopedic device pins, screws or plates**
☐	☐	**Vascular coil, filter, stent**						
☐	☐	**Heart valve replacement**						
☐	☐	**Shunt**	☐	☐	**Shrapnel or gunshot wound**	☐	☐	**Permanent eyeliner, tattoos or piercings**
☐	☐	**Ear surgery or cochlear implant**	☐	☐	**Monitoring device (heart)**			
						☐	☐	**Hearing aid**
☐	☐	**Any known or possibility of metal fragments in the eye**	☐	☐	**Bone growth stimulator**	☐	☐	**Eye prosthesis**
			☐	☐	**TENS unit**	☐	☐	**Claustrophobic**

Describe your symptoms:

FEMALES ONLY

Are you pregnant? Yes ☐ No ☐

Do you have an IUD in place? ☐ Yes ☐ No

Type: Insertion Date:

Do you have inflatable breast implants or tissue expander implants? ☐ Yes ☐ No

MALES ONLY

Do you have a penile prosthesis? ☐ Yes ☐ No

Do you have a tissue expander implant? ☐ Yes ☐ No

I have read the preceding information and answered the questions to the best of my knowledge. I have had all questions regarding this checklist answered by the technologist.

_________________________ / / _________________________

Signature of Patient or Guardian   Date   Relationship to Patient

_________________________ / /

Signature of Technologist   Date