QUESTIONNAIRE FOR MAGNETIC RESONANCE IMAGING

DO YOU HAVE:

A PACEMAKER; DEFIBRILLATOR-CARDIOVERTER	YES	NO
CORONARY STENTS if **YES**, please state the date of the surgery	YES	NO
CLIPS LEFT AFTER BRAIN OR AORTIC ANEURYSM SURGERY	YES	NO
VENTRICULAR OR SPINAL SHUNTS IN THE NERVOUS SYSTEM	YES	NO
ELECTRONIC IMPLANTS: NEUROSTIMULATORS, BIOSTIMULATORS, INSULIN PUMP OR OTHER DRUG DELIVERY SYSTEMS	YES	NO
METAL NAILS OR ORTHOPAEDIC PLATES; ARTIFICIAL LIMB, METAL JOINT REPLACEMENTS	YES	NO
METAL FOREIGN BODIES, SHRAPNEL IN THE BODY OR SKIN (other: working with metal filings); FILINGS IN THE EYE (e.g. metal filings or ocular prosthesis)	YES	NO
HEARING AID IN THE INNER OR MIDDLE EAR, COCHLEAR IMPLANT	YES	NO
ORTHODONTIC APPLIANCES, DENTAL BRIDGES, DENTURES	YES	NO
POSTOPERATIVE METAL CLIPS; SURGICAL METAL SUTURES	YES	NO
A VENTRICULOPERITONEAL SHUNT	YES	NO
A TATTOO OR PERMANENT MAKE UP; METAL ORNAMENTS IN THE BODY	YES	NO

HAVE YOU EVER BEEN DIAGNOSED WITH:

FEAR OF ENCLOSED SPACES - CLAUSTROPHOBIA	YES	NO
SEVERE RENAL IMPAIRMENT?	YES	NO
ALLERGIES, ASTHMA? (TO WHAT?)	YES	NO
ARE YOU PREGNANT? If YES, please specify the month....., weeks of pregnancy	YES	NO
HAVE YOU EVER HAD AN ALLERGIC REACTION TO CONTRAST USED IN IMAGING STUDIES?	YES	NO

I hereby certify that the information provided above is true.

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(date and patient's signature)

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(date and legible signature of the patient's legal representative or an authorised person)