Reichman University

MRI metal questionnaire

Date of study: _____ Time of study: _____

Patient's details: Last name:_____ First name:_____

I.D. No.:_____ Gender:_____ Age:____ Date of birth:_____

Phone number:_____ E-mail:_____

Address:_____

Height: _____ **Weight:**_____

Description	Answer	Comments
A pacemaker, an implantable cardioverter-defibrillator?	Yes / No	
Artificial heart valve?	Yes / No	
Metal in your head following surgery for aneurysm and/ or metal clips?	Yes / No	
A metal bar, plate, screws after surgery?	Yes / No	
Metal shrapnel following injury, accident, or war?	Yes / No	
A cochlear implant (in your ear) or a hearing aid (implanted or removable)?	Yes / No	
A catheter, an infusion pump, an insulin pump, implanted stimulators?	Yes / No	
Permanent makeup, tattoos, or piercing	Yes / No	
Have you ever undergone acupuncture?	Yes / No	
Have all the needles been completely removed from your body?	Yes / No	
Dental prostheses, dental implants, orthodontic device/ braces?	Yes / No	
Orthopedic implants, artificial joints, metal bars, platinum bars, screws, nails?	Yes / No	
Prostheses (eyes, limbs, genitalia, etc.)?	Yes / No	
An expender after breast surgery?	Yes / No	
A stent, a filter, a coil, or any other device implanted into the blood vessels during surgery or catheterization?	Yes / No	
Patches releasing substances/ drugs (e.g., for birth control), patches for electrode connection?	Yes / No	
Any other metals inserted into your body during a surgery, a treatment, or a medical procedure?	Yes / No	
Have you undergone any surgery in the past?	Yes / No	
Are you taking any medication?	Yes / No	
Do you suffer from claustrophobia (fear of enclosed spaces)?	Yes / No	
Have you undergone a gastrointestinal examination using an "imaging pill" – if so, was the pill excreted from your body?	Yes / No	
Are you suffering from any chronic diseases?	Yes / No	
Are there any metals in your working environment (such as in welding)?	Yes / No	
Is it possible that you are pregnant?	Yes / No	
Do you have an IUD?	Yes / No	
Do you have a medical condition that affects your thermoregulation?	Yes / No	
Are you carrying a weapon?	Yes / No	
Have you undergone an MRI examination in the past? If so, were there any problems?	Yes / No	
Have you experienced head trauma or a stroke?	Yes / No	

Are you wearing a wig or hair extensions?	Yes / No	
Do you suffer from epilepsy?	Yes / No	

*Are you left – handed or right – handed? _____

*Is your vision corrected? If so, describe:_____

*Do you have hearing problems? If so, describe:_____

HMO details:

HMO: Clalit / Maccabi / Meuhedet / Leumit / Other:_____

Family Dr.'s name:_____ HMO phone no.:_____

HMO fax no.:_____

I, the undersigned, affirm that all the above are correct and complete:

Name and signature:_____

Filled in by an MRI technician:

Researcher's name:_____ MRI tech name:_____

Protocol:_____ Patient's code:_____

Comments: