LOMPOC VALLEY MEDICAL CENTER
Lompoc Healthcare District

Patient Name: _____
MR#: _____
DOB: _____

MRI Safety Questionnaire

Please answer the following questions by choosing No or Yes.
(*If the answer is Yes, please indicate year and type of implant.)

Aneurysm clips, aneurysm coils, or brain shunt implanted in brain:	☐No	☐Yes	_____
Metal worker (slivers/shavings in eyes) or tattoo/permanent eyeliner:	☐No	☐Yes	_____
Surgeries to eyes where metal, springs, or wires were placed:	☐No	☐Yes	_____
Hearing aids (must be removed before exam) or Cochlear implant:	☐No	☐Yes	_____
Dental work (dentures, partials, dental implant, braces, retainer, etc.):	☐No	☐Yes	_____
Heart pacemaker, defibrillator, or monitor (internal or external battery pack):	☐No	☐Yes	_____
Heart bypass surgery, heart valve replacement, or heart catheter:	☐No	☐Yes	_____
Central-line or port-a-cath for vascular access:	☐No	☐Yes	_____
Stents, coils, filters, umbrella, or grafts implanted:	☐No	☐Yes	_____
Insulin pump, continuous glucose monitor, or infusion pump:	☐No	☐Yes	_____
Neurostimulators, bone or spinal stimulator (internal battery device):	☐No	☐Yes	_____
Implanted electrode wire(s), including pacemaker wires, cardiac defibrillator wires, bone/spinal stimulator wires:	☐No	☐Yes	_____
Bone/joint screws, plates, rods, wires, or pins:	☐No	☐Yes	_____
Joint replacements (shoulder, hips, or knee)	☐No	☐Yes	_____
Shrapnel/bullets:	☐No	☐Yes	_____
Penile implant, pessary, or contraceptive device (IUD):	☐No	☐Yes	_____
Medication patch:	☐No	☐Yes	_____
Do you have diabetes? If yes, what type of diabetes: Type	☐No	☐Yes	_____
Do you have high blood pressure?	☐No	☐Yes	_____

Patient Signature: _____ Date: _____
Reviewer's Signature: _____

When a patient is a minor or incompetent to give consent, signature of person authorized for consent for patient: _____
Relationship to patient: _____

Revised: 05.15.2023