SAFETY SCREENING QUESTIONNAIRE
MRI (Magnetic Resonance Imaging)

Name :_____ Date of birth: | | | | | | |

First name: _____ Weight : kg

Size : cm

	YES	NO
Have you ever had a MRI exam before?	☐	☐
Do you have a pacemaker, an implanted heart defibrillator or a neuro-stimulator?	☐	☐
Do you have an insulin pump?	☐	☐
Have you had any operations on your head?	☐	☐
Have you any metal fragments in your body?	☐	☐
• Implants, heart valve, stents or clips after surgical intervention, IUD, piercing	☐	☐
• Fragments of metal (in particular in the eyes)	☐	☐
Do you suffer from any food or drug allergy or do you have asthma? If yes, which: _____	☐	☐
Do you suffer from kidney disease or kidney failure?	☐	☐
Do you have any tattoos or permanent makeup?	☐	☐
Do you have an ear implant?	☐	☐
Do you wear dentures?	☐	☐
Do you wear a medicine patch? (Ex. NICOTINELL®, SCOPODERM®)?	☐	☐
Do you suffer from claustrophobia?	☐	☐
Have you had any operation in the body part to exam? If yes, which: _____ When?	☐	☐
Female patients only : Are you, or could you be, pregnant?	☐	☐
Are you breast feeding?	☐	☐

Remarks / additional information? _____

_____

_____

By signing below, I confirm to have read the information about this exam and understood and correctly answered this questionnaire and give my consent to the conduct this exam. To better assess my case, I accept that Affidea can request previous reports or exams.

Signature of patient: _____ Date : | | | | | | |