

## Security questionnaire Radiology (MRI / CT)

### Dear Patient

Please complete the questionnaire to the best of your ability.

Our staff will be happy to help you if you have questions or if you are unsure about anything.

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ DOB : \_\_\_\_\_

When do you have an appointment to discuss the findings? Date: \_\_\_\_\_

<b>Do you have...</b>	a pacemaker?	<input type="checkbox"/> yes	<input type="checkbox"/> no
	an artificial heart valve?	<input type="checkbox"/> yes	<input type="checkbox"/> no
	a neurostimulator or a pain pump?	<input type="checkbox"/> yes	<input type="checkbox"/> no
	metal on/in your body? <input type="checkbox"/> piercings, <input type="checkbox"/> artificial joints, <input type="checkbox"/> screws, <input type="checkbox"/> clips <input type="checkbox"/> stents, <input type="checkbox"/> acupuncture needles, <input type="checkbox"/> gunshot wounds, <input type="checkbox"/> other Where? _____	<input type="checkbox"/> yes	<input type="checkbox"/> no
	If so, was it implanted before 1990?	<input type="checkbox"/> yes	<input type="checkbox"/> no
	an insulin pump? blood glucose sensor?	<input type="checkbox"/> yes	<input type="checkbox"/> no
	metal fragments in your body? (e.g. in your eye)	<input type="checkbox"/> yes	<input type="checkbox"/> no
	<input type="checkbox"/> hearing aid? (Please remove it before the investigation) <input type="checkbox"/> cochlear implant?	<input type="checkbox"/> yes	<input type="checkbox"/> no
	a dental prosthesis?	<input type="checkbox"/> yes	<input type="checkbox"/> no
	a tattoo?	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>Do you take...</b>	blood-thinning medication? <input type="checkbox"/> Aspirin Cardio <input type="checkbox"/> Marcoumar <input type="checkbox"/> Xarelto <input type="checkbox"/> Other	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>Have you had ...</b>	heart surgery or an operation on your head (brain, ear, eye)? What type of surgery? _____	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>Do you have...</b>	asthma or allergies, in particular to contrast agents? Which one(s)? _____	<input type="checkbox"/> yes	<input type="checkbox"/> no
	claustrophobia?	<input type="checkbox"/> yes	<input type="checkbox"/> no
	an overactive thyroid?	<input type="checkbox"/> yes	<input type="checkbox"/> no
	<input type="checkbox"/> diabetes or <input type="checkbox"/> renal disease or renal insufficiency?	<input type="checkbox"/> yes	<input type="checkbox"/> no
	a lung disease?	<input type="checkbox"/> yes	<input type="checkbox"/> no
	on serious heart or blood vessel disease? Where? _____	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>For women:</b>	Are you pregnant or are you breastfeeding?	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>Your height:</b> _____ cm <b>Your weight:</b> _____ kg			

I herewith confirm that I have understood the information and that I have answered the above-listed questions truthfully. With my signature I give my consent to the investigation being carried out

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

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