



**Before the examination of MRI, please answer carefully to the following questions :**

**Name :** ..... **Surname :** ..... **Date of birth :** ...../..... /..... **Weight :** .....Kg **Height :** .....m....

 Have you got a **pacemaker, implantable cardiac defibrillator, implantable Holter or neurostimulator ?** Yes  No


Have you ever had heart surgery (**heart valve prothesis, stent, caval filter, coronary bypass**) ? Yes  No   
If so : - year of the implant : ..... - type : .....

 Have you ever had **brain surgery ?** Yes  No   
If so, with implant (**neurosurgical clips, cerebral ventricular shunt, cochlear implant**) ? Yes  No

 Did you spend a scintigraphy or Petscan there less than 48 hours ? Yes  No


 Have you got **dentures or rings orthodontie ?** Yes  No

 Are you **diabetic ?** Yes  No   
If so, do you carry on insulin pump Yes  No

 Have you got **surgical prosthesis?** (hip, knee,nails,screws,skin expander. Yes  No

 Have you got **hearing aid ?** Yes  No

Do you suffer from **kidney dysfunction ?** Yes  No

 **Are you pregnant or think you could be pregnant ?** Yes  No

**Are you breastfeeding ?** Yes  No

Do you suffer from allergies (drugs, food, **asthma, iodine**) ? Yes  No

Have you got a blood pressure treatment (**Bêta-blocker**) ? Yes  No

Have you got a **transdermal patch ?** Yes  No

**Have you had surgery there are less than 2 months ?** Yes  No

Have you got **metallic splinters** (bullets, shells) ? Yes  No

Do you work with metal (**metallic splinters in eyes**) ? Yes  No

Are you **claustrophobic or anxious ?** Yes  No

**Information** that seems **significant** to be communicated and **serious illness** (**Hepatitis C, HIV, cancer...**) or **previous surgical intervention**

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Due to the strong magnetic field and waves from the MRI, **some items are not allowed in the examination room**, a safe is at your disposal:

- **Hearing aid, dentures, jewels, piercings**
- **Credit card, magnetic card, coins**
- **Mobile phone, watch, keys, lighter**

**I declare to have been informed of various details and risks related to the examination. I give my consent for my personal data to be archived and transmitted to the medical profession (medical specialist, CPR, attendind physician...)**

**Done in Grasse, on** ..... **Signature,**

MAJ 30/05/2022

*In accordance with the law relating to computers, files and freedom of 06/01/1978, you have a right to access, rectify and delete data concerning you and opposition to their treatment.*

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**Before the examination of SCANNER or MRI, please answer carefully to the following questions :**

**Surname :** ..... **Name :** ..... **Date of birth :** ..... / ..... / .....

**Have you contracted covid 19 ?** YES  NO

**If yes,** on what date your test was positive ? .....

**In the past 48 hours have you had any of the following symptoms :**

- Cough ? ..... YES  NO
- Body aches ..... YES  NO
- Fever (chills, sweat) ..... YES  NO
- Difficulty breathing ? ..... YES  NO
- Loss of taste or smell ? ..... YES  NO
- Diarrhea ..... YES  NO

**Have you had Covid cases around you ?** YES  NO



**I hereby certify on the honor that I answered this questionnaire sincerely**

**Done in Grasse, on** ..... / ..... / .....

**Signature :**

**Read and Approved**

30/05/2022