

MRI PATIENT QUESTIONNAIRE

Please answer the questions to the best of your ability and review any questions left unanswered with the technologist

Name: _____ DOB: ___/___/___ Approx. Weight: _____ lbs

1) Please indicate the symptoms that you are having that pertain to your MRI today:

- | | | |
|---|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Arm (right / left) | <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Vision Loss, changes | <input type="checkbox"/> Leg (right / left) | <input type="checkbox"/> Foot (right / left) |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Knee (right / left) | <input type="checkbox"/> Shoulder (right / left) |
| <input type="checkbox"/> Numbness in arms or legs | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Other |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Upper Back | _____ |
| <input type="checkbox"/> Lump or Mass (location) | <input type="checkbox"/> Neck | _____ |

2) How long have you had these symptoms? _____

3) Is this the result of an injury? Yes No
If yes, please describe: _____

4) Have you ever had an MRI or X-Ray of the part being scanned today? Yes No
If yes, where and when was it performed? _____

5) Have you ever had any previous surgeries on the part being scanned today? Yes No
If yes, please describe: _____

6) Have you (past/present) been diagnosed with cancer? Yes No
Location in your body: _____

7) Have you had radiation therapy or chemotherapy? Yes No

8) Is there any chance of pregnancy? Yes No Date of last menstrual period: _____

9) Are you breastfeeding? Yes No

10) Have you ever worked with metal (grinding, fabricating, etc.) or ever had any injury to the eye involving a metallic object (metallic silvers, shavings, foreign body, etc)? Yes No

11) Do you have any known allergies? Yes No
If yes, please list: _____

12) Do you have anemia or any diseases that affect your blood, a history of renal disease, diabetes or seizures? Yes No
If yes, please describe: _____

13) Have you ever had asthma, allergic reaction, respiratory distress or other reactions to a contrast medium or dye used for an MRI or CT Scan examination? Yes No

14) If a contrast injection is deemed necessary by the ordering physician or radiologist, I will give my informed consent to be given the injection. Yes No

Patient Signature: _____ **Date:** _____

(CONTINUED ON BACK)

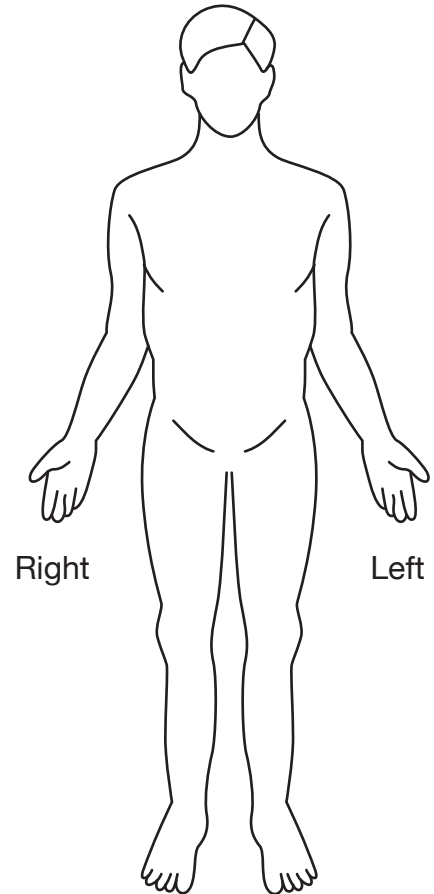
THE FOLLOWING ITEMS MAY BE HAZARDOUS OR MAY INTERFERE WITH THE MRI EXAMINATION BY PRODUCING AN ARTIFACT

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

YES NO

- Cardiac pacemaker
- Aneurysm clip(s)
- Implanted cardiac defibrillator
- Neurostimulator
- Any type of biostimulator
Type: _____
- Any type of internal electrode(s), including:
Pacing wires
Cochlear implant
Other: _____
- Implanted insulin pump
- Swan-Ganz catheter
- Halo vest or metallic cervical fixation device
- Any type of electronic, mechanical or magnetic implant
Type: _____
- Hearing aid
- Any type of intravascular coil, filter or stent
(Gianturco coil, Gunther IVC filter, Palmaz stent, etc.)
- Implanted drug infusion device
- Any type of foreign body, shrapnel or bullet
- Heart valve prosthesis
- Any type of ear implant
- Penile prosthesis
- Orbital/eye prosthesis
- Any type of implant held in place by a magnet
- Any type of surgical clip(s) or staple(s)
- Vascular access port
- Intraventricular shunt
- Artificial limb or joint
- Dentures
- Diaphragm
- IUD
- Pessary
- Wire mesh
- Any implanted orthopedic item(s) (pins, rods, screws, nails, clips, plates, wires, etc.)
Type: _____
- Any other implanted item
Type: _____
- Tattooed eyeliner*

Please mark on this drawing the location of any metal in your body.



** A small percentage of patients with tattooed eyeliner have experienced transient skin irritation in association with MRI. Therefore, you must decide if this slight risk warrants undergoing your examination. You may want to discuss this matter with your referring physician.*

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient Signature: _____ **Date:** _____

RT Signature: _____ **Date:** _____

RT Name: _____