MRI QUESTIONNAIRE

Patients Name:_____Todays Date:_____
M / F D.O.B.:_____ Weight:_____ File #_____

Please circle 'yes' or 'no' to the following questions:

YES NO Have you ever had metal in your eyes or body? (i.e., gun shot wound, metal shavings from grinding or welding, lead pencil injury)

YES NO Do you have a Pacemaker for your Heart?

YES NO Have you ever had surgery on your Brain or Heart?

YES NO Do you have any Aneurysm clips in your Brain or Chest or Abdomen?

YES NO Do you have any type of electronic, mechanical or magnetic implant? (i.e., penile implant, neurostimulators, biostimulator, drug pumps, breast tissue extenders, coils, cochlear implant or any other type of ear implant, internal electrodes, artificial heart valve, eyelid spring, surgical mesh, magnetic dentures)

YES NO Do you have any medication patches on today? (i.e., nitroglycerine, nicotine)

YES NO Do you have a removable prosthesis (i.e., artificial limb, hearing aid)

YES NO Do you have a tattoo? (eyeliner, eyebrow, other)

YES NO Body piercings may carry a risk of injury, do you have any?

YES NO Do you have a history of Kidney disease? If so, are you on Dialysis?

YES NO Have you ever been diagnosed with any type of Cancer?

YES NO Do you have any drug allergies?

YES NO Do you have a history of Asthma?

YES NO Are you currently breast feeding an infant?

For the body part we are to exam today, have you ever had any of the following? ( )MRI ( )CT ( )X-Ray ( ) Nuclear Medicine ( ) Other _____ Tell us where:_____
and approximately when they were taken:_____.

BRIEFLY describe your symptoms (include which side they are on) and how long you've had them or date of injury:_____

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 or Guardian signature:_____ Date_____

Technologist signature: _____

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