

MRI QUESTIONNAIRE

TORSO AND EXTREMITIES

TODAY'S DATE _____

APPOINTMENT DATE _____

NAME _____ SS# _____

SEX _____ AGE _____ WT _____

DO YOU HAVE A PACEMAKER, OR ANY OTHER IMPLANTED DEVICES?
HAVE YOU HAD ANY BRAIN SURGERY?
HAVE YOU HAD ANY EYE OR EAR SURGERY OTHER THAN CATARACT/LENS IMPLANTS?
HAVE YOU EVER DONE ANY SHEET METAL/WELDING WORK?
IS THERE ANY CHANCE YOU ARE PREGNANT?
DO YOU HAVE ANY METAL ANYWHERE IN YOUR BODY THAT WE SHOULD KNOW ABOUT?
HAVE YOU EVER BEEN SHOT WITH A BULLET OR BB?

FOR OFFICE USE ONLY		

IF YOUR ANSWER IS YES TO ANY OF THESE PLEASE NOTIFY THE FRONT DESK BEFORE FINISHING FORM!!!!

ORDERING DOCTOR _____

OTHER DOCTORS NEEDING REPORTS _____

(PLEASE MAKE SURE FRONT DESK HAS ADDRESS/PH # OF ANY DOCTORS YOU NEED REPORTS SENT TO.)

HAVE YOU HAD ANY PREVIOUS MRI'S? _____

IF SO, WHERE AND WHEN? _____

HAVE YOU HAD OTHER TESTS OF THE SAME BODY PART WE ARE EXAMINING TODAY? _____

IF YES, WHAT KIND AND WHERE WERE THEY DONE? _____

ANY KNOWN ALLERGIES? _____

ANY KNOWN SURGERIES YOU HAVE HAD? _____

DO YOU HAVE: HIGH BLOOD PRESSURE? _____, DIABETES? _____, HEART DISEASE? _____

KNOWN TUMORS? _____

ARE YOU CURRENTLY A DIALYSIS PATIENT? _____

HAVE YOU HAD ANY RADIATION TREATMENTS? _____

HAVE YOU EVER HAD ANY CHEMOTHERAPY? _____

ARE YOU ON ANY SEIZURE MEDIATION? _____

ARE YOU TAKING ANY STEROID MEDICATION? _____

ARE YOU RIGHT OR LEFT HANDED? _____

IF YOU HAVE ANY OF THE FOLLOWING, PLEASE LET THE TECHNOLOGIST KNOW BEFORE YOU ARE TAKEN INTO THE SCAN ROOM. THE MAGNETIC FIELD IS ALWAYS ON AND SOME ITEMS BELOW NEED TO BE CHECKED OR REMOVED BEFORE ENTERING SCAN ROOM.

CARDIAC PACEMAKER
HEARING AIDS/IMPLANTS
HEART VALVES
ARTIFICIAL EYE
ANEURYSM CLIPS

DENTURES
SHUNTS
NEUROSTIMULATOR
BRAIN SURGERY
PROSTHESIS

INSULIN/MEDICATION PUMP
JOINT REPLACEMENTS/RODS
BULLET
BB

PLEASE ANSWER QUESTIONS ON BACK AND RETURN TO FRONT DESK

TORSO AND EXTREMITIES

DO YOU HAVE?

	YES	NO	RIGHT	LEFT	BOTH
NECK PAIN					
SHOULDER PAIN					
ARM PAIN/NUMBNESS					
INABILITY TO RAISE ARM					
HIP PAIN					
KNEE PAIN					
LOWER LEG PAIN					
ABDOMINAL PAIN					
PELVIC PAIN					
BLOOD IN URINE					
NAUSEA/VOMITING					

IF YOU HAVE HAD AN INJURY, PLEASE EXPLAIN WHAT HAPPENED. _____

IF YOU HAVE ANY SYMPTOMS NOT LISTED PLEASE EXPLAIN. _____

ARE YOU HERE BECAUSE OF A LUMP/MASS? _____ IF SO PLEASE STATE HOW LONG YOU HAVE HAD IT AND
IF ITS GOTTEN BIGGER _____
ALSO, PLEASE SHOW TECHNOLOGIST LOCATION OF LUMP SO IT CAN BE MARKED BEFORE SCAN.

**I HAVE READ THIS FORM ENTIRELY AND UNDERSTAND WHAT I HAVE READ. I WILL NOT
HOLD ANY PERSON OR INSTITUTION RESPONSIBLE FOR ANY OMISSIONS MADE HERE:**

SIGNATURE: _____ **DATE:** _____

WITNESS: _____ **DATE:** _____