MRI QUESTIONNAIRE

HEAD AND SPINE

TODAY'S DATE ____________

APPOINTMENT DATE ____________

NAME ____

BIRTH DATE ____________________ SEX ______ AGE _______ WEIGHT ________________

FOR OFFICE USE ONLY

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? ________________________

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.)

WHAT IS THE PRIMARY REASON YOUR DOCTOR SENT YOU HERE FOR THIS TEST. ________________________

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 MEDICATION?________________________

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

Revised 10/06

PLEASE ANSWER QUESTIONS ON BACK AND RETURN TO FRONT DESK

HEAD AND SPINE

DO YOU HAVE?

	YES	NO
HEADACHES		
SEIZURES		
MEMORY LOSS		
TROUBLE WALKING		
DIZZINESS		
LIGHTHEADEDNESS		
LOSS OF SMELL		
NAUSEA/VOMITTING		
SPEECH DIFFICULTY		
BLURRY VISION		

IF YOU HAVE ANY OF THE FOLLOWING, PLEASE DENOTE WHICH SIDE

	YES	NO	RIGHT	LEFT	BOTH
FACIAL PAIN					
FACIAL NUMBNESS/PARALYSIS					
HEARING LOSS					
VISION LOSS					
NECK PAIN					
ARM PAIN					
ARM TINGLING/NUMBNESS					
ARM WEAKNESS/PARALYSIS					
BACK PAIN					
LEG PAIN					
LEG TINGLING/NUMBNESS					
LEG WEAKNESS/PARALYSIS					

IF YOU HAVE ANY SYMPTOMS NOT MENTIONED ABOVE, PLEASE EXPLAIN.

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____

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:** ________________