

MRI PATIENT HISTORY & QUESTIONNAIRE

**** If you have a PACEMAKER you CANNOT have a MRI****

NAME: _____ M or F DATE: _____

AGE: _____ WEIGHT: _____ HEIGHT: _____ DOB: _____

REFERRING DR: _____

DO YOU HAVE ANY OF THE FOLLOWING? (CIRCLE YES OR NO)

Have you ever had a MRI exam? Y N Area Scanned: _____ Facility and Date: _____

Have you ever had surgery on the area we are scanning today? Y N Explain: _____

PACEMAKER / Cardiac Defibrillator/ Wires ? Y N * **You CANNOT have a MRI with a PACEMAKER**

ANEURYSM Clip in Brain? Y N * **You MAY NOT be able to have MRI!**

Surgery within the last 6 WEEKS? Y N _____

Metal / Shrapnel / Bullets/ Piercings in Body? Y N _____

Ear or Eye implants (stapes / cochlear)? Y N _____

Any Stent / Implant / Shunt / Valve / Clamp? Y N _____

Are you wearing a Medicine Patch? Y N _____

Kidney Disease or Dialysis ? Y N _____

IUD / Penile implant ? Y N _____

Have you ever had a diagnosis of Cancer? Y N Treatment Type: _____

Tattoo Eyeliner (possible Metal in Ink)? Y N _____

Removable Dental Work / Hearing Aids? Y N _____

Neuro / Bone Stimulator /Tens Unit ? Y N _____

Metal in Eyes in the Past? Y N Removed by Doctor? Y N

Diabetic? Y N Implanted Insulin Pump Y N

Chance of pregnancy? Y N Are you Breast Feeding? Y N

List Drug Allergies _____

List all Past Surgeries _____

Indicate Right or Left Arm or Leg problems – pain – numbness (Describe symptoms) :

For the Radiologist describe your symptoms/problems :

To the best of my knowledge, the answers I have given are complete and correct. I understand I will be entering a magnetic field where ferrous metals (attracts to a magnet) can be dangerous and/or life threatening.

PATIENT'S SIGNATURE _____

*****DO NOT WRITE BELOW THIS LINE **** FOR TECHNOLOGIST USE ONLY*****

EXAM/ HISTORY: MRI _____

Contrast : _____ Injection Site: _____ Technologist Signature: _____