



MRI Patient Questionnaire

Place Patient Label Here

Date	Age	Date of Birth
/ /	Years Old	Social Security # - - - - -

1. Have you had prior surgery or an operation (e.g. arthroscopy, endoscopy, etc) of any kind? No Yes
 If yes, please indicate the date and type of surgery below:

Type:	Date:	Type:	Date:
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2. Have you had a previous Diagnostic Imaging study or examination (MRI, CT, Ultrasound, X-ray, etc)? No Yes
 If yes, please indicate the date, facility name and address, phone number and body parts.

Procedure	Date	Body Part	Facility Name & Address	Phone No.
MRI				
CT/ CAT SCAN				
X-RAY				
ULTRASOUND				
NUCLEAR MEDICINE				
OTHER				

3. Have you experienced any problem related to a previous MRI examination or MR procedure? No Yes

4. Have you had an injury to the eye involving a metallic object or fragment (e.g. metallic silver shavings, foreign body, etc)? No Yes
 If yes, please describe:

5. Have you ever been injured by a metallic object or foreign body (e.g. BB, Bullet, Shrapnel, etc)? No Yes

6. Have you ever worked as a hobbyist or through employment in a metal shop, tool and die shop, or handled power tools involved in cutting or welding metal, or engaged in similar activities using metal? No Yes

7. Are you currently or have recently taken any medication or drug? No Yes

8. Are you allergic to any medication? No Yes

9. Have you ever had an allergic reaction to iodine, or any other contrast material or dye used for an MRI or CT examination? No Yes

10. Do you have anemia or any disease(s) that your blood, a history of renal (kidney) disease or seizure? No Yes

FOR FEMALE PATIENTS

11. Are you pregnant?

No Yes

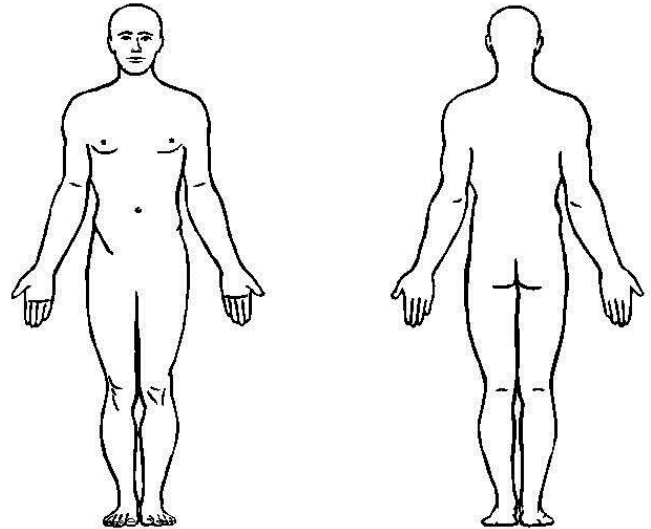


WARNING: Certain implants, devices or objects may be hazardous to you and/ or may interfere with the MRI procedure (i.e. MRI, MRI angiography, functional MRI, MRI spectroscopy). Do not enter the MRI system room or MRI environment if you have any questions or concerns regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MRI system room. The MRI system magnet is **ALWAYS** on.

Please indicate if you have any of the following:

Aneurysm clip(s)	No <input type="checkbox"/> Yes <input type="checkbox"/>
Cardiac Pacemaker	No <input type="checkbox"/> Yes <input type="checkbox"/>
Implanted cardioverter defibrillator (ICD)	No <input type="checkbox"/> Yes <input type="checkbox"/>
Electronic Implant or device	No <input type="checkbox"/> Yes <input type="checkbox"/>
Magnetically-activated implant or device	No <input type="checkbox"/> Yes <input type="checkbox"/>
Neurostimulation system	No <input type="checkbox"/> Yes <input type="checkbox"/>
Spinal cord stimulator	No <input type="checkbox"/> Yes <input type="checkbox"/>
Internal electrodes or wires	No <input type="checkbox"/> Yes <input type="checkbox"/>
Bone growth/bone fusion stimulator	No <input type="checkbox"/> Yes <input type="checkbox"/>
Cochlear, otologic, or other ear implant	No <input type="checkbox"/> Yes <input type="checkbox"/>
Insulin or other infusion pump	No <input type="checkbox"/> Yes <input type="checkbox"/>
Implanted drug infusion device	No <input type="checkbox"/> Yes <input type="checkbox"/>
Any type of prosthesis (eye, penile, etc)	No <input type="checkbox"/> Yes <input type="checkbox"/>
Heart valve prosthesis	No <input type="checkbox"/> Yes <input type="checkbox"/>
Eyelid spring or wire	No <input type="checkbox"/> Yes <input type="checkbox"/>
Artificial or prosthetic limb	No <input type="checkbox"/> Yes <input type="checkbox"/>
Metallic stent, filter or coil	No <input type="checkbox"/> Yes <input type="checkbox"/>
Shunt (spinal or intraventricular)	No <input type="checkbox"/> Yes <input type="checkbox"/>
Vascular access port and/or catheter	No <input type="checkbox"/> Yes <input type="checkbox"/>
Radiation seeds or implants	No <input type="checkbox"/> Yes <input type="checkbox"/>
Swan-Ganz or thermo dilution catheter	No <input type="checkbox"/> Yes <input type="checkbox"/>
Medication patch (Nicotine, Nitroglycerine)	No <input type="checkbox"/> Yes <input type="checkbox"/>
Any metallic fragment or foreign body	No <input type="checkbox"/> Yes <input type="checkbox"/>
Wire mesh implant	No <input type="checkbox"/> Yes <input type="checkbox"/>
Tissue expander (e.g. breast)	No <input type="checkbox"/> Yes <input type="checkbox"/>
Surgical staples, clips, or metallic sutures	No <input type="checkbox"/> Yes <input type="checkbox"/>
Joint replacement (hip, knees, etc)	No <input type="checkbox"/> Yes <input type="checkbox"/>
Bone/joint pin, screw, nail, wire, plate. Etc.	No <input type="checkbox"/> Yes <input type="checkbox"/>
IUD, diaphragm, pessary	No <input type="checkbox"/> Yes <input type="checkbox"/>
Dentures or partial plates	No <input type="checkbox"/> Yes <input type="checkbox"/>
Tattoo or permanent makeup	No <input type="checkbox"/> Yes <input type="checkbox"/>
Body piercing jewelry	No <input type="checkbox"/> Yes <input type="checkbox"/>
Hearing aid	No <input type="checkbox"/> Yes <input type="checkbox"/>
(remove before entering MRI system room)	
Other implant	No <input type="checkbox"/> Yes <input type="checkbox"/>
Breathing problem or motion disorder	No <input type="checkbox"/> Yes <input type="checkbox"/>
Claustrophobia	No <input type="checkbox"/> Yes <input type="checkbox"/>

Please mark on the figure(s) below, the location of any implant or metal inside of your body.



IMPORTANT INSTRUCTIONS

Before entering the MRI environment or MRI system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pin, barrettes, jewelry, body piercing, watch, safety pins, paper clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners and clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any questions or concerns **BEFORE** you enter the MRI system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MRI procedure to prevent possible problems or hazards to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedures that I am about to undergo. I acknowledge that DMI is not responsible for injury or damage that may occur to my body or any device, whether implanted or otherwise (including watches, hearing aids, or implanted medical devices) resulting from bringing such devices into the MR system room.

Signature of Person Completing Form:

Date:

Form Completed by:

Patient Relative Nurse

Name:

Relationship to Patient:

Form Information Reviewed by:

Physician Name:

Signature:

MRI Technologist: