

# MRI QUESTIONNAIRE

Name \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_  
Last First Middle

Sex: M \_\_\_ F \_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ ft \_\_\_\_\_ in. Referring physician: \_\_\_\_\_

Were you injured? Yes \_\_\_\_\_ No \_\_\_\_\_ Is this injury work related? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, date and how? \_\_\_\_\_

Describe any symptoms relating to **TODAY'S** exam (aching, burning, pin, and needles, radiating, stabbing, weakness, etc.)

Have you had any of the following (**related to this problem**)? (please mark all that apply)

Surgery \_\_\_\_\_ Ct Scans \_\_\_\_\_ Xrays \_\_\_\_\_ MRIs \_\_\_\_\_

If yes, when, and where, and the results? \_\_\_\_\_

Please use back to add additional information

A creatinine blood screening will be done on all patients with the following conditions to assess renal function before injecting contrast. Please answer completely. Do you have any of the following?

Diabetes & Meds \_\_\_\_\_ Hypertension & Meds \_\_\_\_\_ Kidney Disease \_\_\_\_\_ Cancer Treatment \_\_\_\_\_

Please list all medications: \_\_\_\_\_

Do you any of the following? (please circle)

- Yes No Heart Surgery / Heart Valve / Pacemaker / Defibrillator
- Yes No Brain Surgery / Brain Aneurysm Clips If yes, explain: \_\_\_\_\_
- Yes No Injury to eye involving metal or metal shavings
- Yes No Have you done any welding?
- Yes No Neurostimulator / Biostimulator
- Yes No Penis Prosthesis
- Yes No History of tumor \_\_\_\_\_
- Yes No Surgery on Spine (neck or back) \_\_\_\_\_
- Yes No Hearing Aids / Ear Surgery / Cochlear Implants
- Yes No Any type of Electrical / Magnetic or mechanical Implants on or in your body \_\_\_\_\_
- Yes No Implanted Drugs Infusion Pump / Insulin Pump
- Yes No Are you pregnant or nursing? Last Menstrual Period? \_\_\_\_\_
- Yes No Gunshot wounds / Shrapnel / BB's
- Yes No History of any metallic implant(s), OTHER than dental work, not mentioned/listed above?  
If yes, explain: \_\_\_\_\_
- Yes No Will you be seeing a surgeon or specialist?  
If yes, when is the next appointment with your doctor or specialist? \_\_\_\_\_

## OFFICE USE ONLY

Time In \_\_\_\_\_ Time Out \_\_\_\_\_ Stat Yes No  
Exam Ordered: \_\_\_\_\_  
Diagnosis \_\_\_\_\_  
Referring Physician \_\_\_\_\_  
Phone \_\_\_\_\_  
Contrast injected: \_\_\_\_\_ Lot# \_\_\_\_\_ Exp Date: \_\_\_\_\_  
Volume: \_\_\_\_\_ ml Time: \_\_\_\_\_ Injection site: \_\_\_\_\_  
Comments \_\_\_\_\_  
NDC # \_\_\_\_\_ Tech's Initials \_\_\_\_\_