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?_____

Decribe 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 / Defibrilator
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 Electical / 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_____