IMAGING SERVICES

MAGNETIC RESONANCE IMAGING (MRI) QUESTIONNAIRE – OUTPATIENT

Instruction:
To be completed by patient prior to MRI. Side 1 of 2

Sex: ☐ Male ☐ Female Age: __________ Estimated weight: __________ Estimated height: __________

Reason for MRI and/or symptoms: __________________________________________________________
_____________________________________________________________________________________

Referring/ordering physician: _______________________________________________________________

WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MRI procedure. Do not enter the MRI system room or MRI environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist BEFORE entering the MRI room. The MRI Magnet is ALWAYS on.

Do you have, or have you had any of the following:

☐ Yes ☐ No Cardiac pacemaker           ☐ Yes ☐ No Vascular access port and/or catheter
☐ Yes ☐ No Implanted cardioverter defibrillator (ICD) ☐ Yes ☐ No Radiation seeds or implants
☐ Yes ☐ No Aneurysm clip(s)            ☐ Yes ☐ No Swan-Ganz or thermodilution catheter
☐ Yes ☐ No Brain surgery               ☐ Yes ☐ No Skin patch (e.g., Nicotine, Nitroglycerine, pain)
☐ Yes ☐ No Electronic implant or device ☐ Yes ☐ No Any metallic fragment or foreign body
☐ Yes ☐ No Magnetically-activated implant or device ☐ Yes ☐ No Wire mesh implant
☐ Yes ☐ No Neurostimulation system      ☐ Yes ☐ No Tissue expander (e.g., breast)
☐ Yes ☐ No Spinal cord stimulator       ☐ Yes ☐ No Surgical staples, clips, or metallic sutures
☐ Yes ☐ No Internal electrodes or wires ☐ Yes ☐ No Joint replacement (e.g., hip, knee)
☐ Yes ☐ No Bone growth/bone fusion stimulator ☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate
☐ Yes ☐ No Cochlear, otologic, or other ear implant ☐ Yes ☐ No IUD, diaphragm, or pessary
☐ Yes ☐ No Insulin or other infusion pump ☐ Yes ☐ No Dentures, or partial plates
☐ Yes ☐ No Implanted drug infusion device ☐ Yes ☐ No Color contact lenses
☐ Yes ☐ No Any type of prosthesis (e.g., eye, penile) ☐ Yes ☐ No Tattoo or permanent makeup
☐ Yes ☐ No Heart valve prosthesis       ☐ Yes ☐ No Body piercing jewelry
☐ Yes ☐ No Eyelid spring or wire        ☐ Yes ☐ No Hearing aid
☐ Yes ☐ No Artificial or prosthetic limb ☐ Yes ☐ No Other implant: _______________________
☐ Yes ☐ No Metallic stent, filter, or coil ☐ Yes ☐ No Breathing problem or motion disorder
☐ Yes ☐ No Shunt (e.g., spinal, intraventricular) ☐ Yes ☐ No Claustrophobia

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

2. Have you had a prior diagnostic imaging study or examination of the same body part we are imaging today (MRI, Computerized tomography (CT), Ultrasound, X-ray, etc.)?
   ☐ Yes ☐ No If yes, list: __________________________

3. Have you ever done any sheet metal/welding work? ☐ Yes ☐ No
   If yes, did you always wear eye protection? ☐ Yes ☐ No

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ☐ Yes ☐ No

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?
   ☐ Yes ☐ No If yes, describe: __________________________
6. Are you pregnant or possibly pregnant? □ Yes □ No
7. Are you breastfeeding? □ Yes □ No
8. Are you allergic to any medications? □ Yes □ No If yes, list and describe reaction: ____________________________
9. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? □ Yes □ No If yes, describe: ____________________________
10. Do you have anemia or any disease(s) that affects your blood, a history of kidney disease, kidney failure, kidney transplant, high blood pressure (hypertension), liver disease, a history of diabetes, or seizures? □ Yes □ No If yes, describe: ____________________________

Please complete the following section ONLY if you are scheduled for an MRI of head or spine. If not, proceed to signature portion at the bottom of page.

1. Have you ever had radiation treatments? □ Yes □ No
2. Have you ever had chemotherapy? □ Yes □ No
3. Do you have headaches? □ Yes □ No
4. Do you have memory loss? □ Yes □ No
5. Do you have trouble walking? □ Yes □ No
6. Do you have dizziness? □ Yes □ No
7. Do you have blurry vision? □ Yes □ No

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<thead>
<tr>
<th>If you have any of the following, please mark:</th>
<th>Yes</th>
<th>No</th>
<th>If yes, which side:</th>
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</thead>
<tbody>
<tr>
<td>Facial pain</td>
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<td>Facial numbness/paralysis</td>
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<td>Hearing loss</td>
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<td>Vision loss</td>
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<td>Neck pain</td>
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<td>Arm pain</td>
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<td>Arm tingling/numbness/weakness/paralysis</td>
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<td>Back pain</td>
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<td>Leg tingling/numbness/weakness/paralysis</td>
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NOTE: You will be required to wear earplugs or other hearing protection during the MRI procedure to prevent problems or hazards related 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 MRI procedure that I am about to undergo.

Signature of Patient/Representative ____________________________ Relationship to Patient ____________________________ Date __/__/____ Time __:__