

**MRI QUESTIONNAIRE**

Name: \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ WT \_\_\_\_\_

**PATIENTS WITH CEREBRAL ANEURYSM CLIPS OR PACEMAKERS CANNOT UNDERGO AN MRI**

Describe your symptoms: \_\_\_\_\_

Have you ever had an injury to this area? Yes No If so, when? \_\_\_\_\_

Have you had previous x-rays of this area? Yes No If so, when? \_\_\_\_\_ Where? \_\_\_\_\_

Please list all surgeries: \_\_\_\_\_

**DO YOU HAVE A PACEMAKER?** Yes No

**IF YES, PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY**

Are you currently on dialysis or have chronic renal failure? Yes No

Have you ever worked as a metal worker? Yes No

If yes, could you have metal in your head, eyes or skin? Yes No

Do you have metal plates, pins, screws, nails or clips in your body? Yes No

Do you wear a hearing aid? Yes No

Do you have implanted devices? Yes No

Could you be pregnant? Date of last menstrual period: \_\_\_\_\_ Yes No

Have you ever had surgery on your head (ex: brain, ears or eyes)? Yes No

Is this procedure being done due to a work-related injury? Yes No

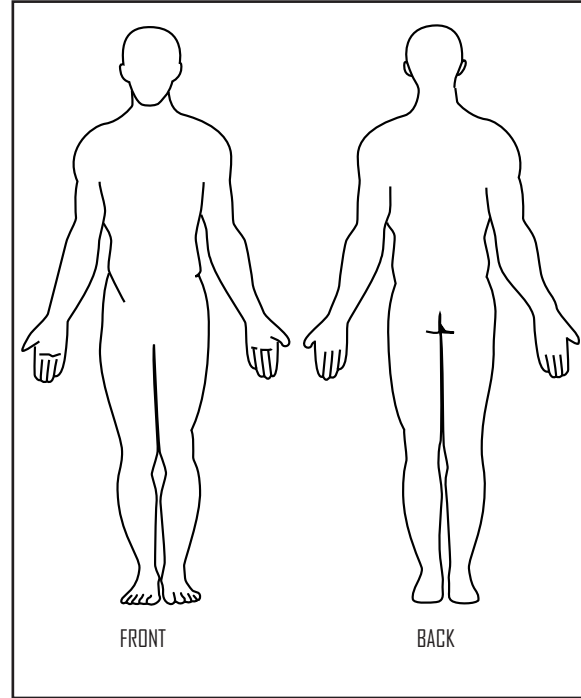
Is this procedure being done due to an automobile accident? Yes No

Do you have numbness or weakness in your arms or legs? Yes No

Please specify: \_\_\_\_\_

Do you have pain which radiates into your arms or legs? Yes No

If so, specify right, left, arm or leg: \_\_\_\_\_



Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.).

**DO YOU HAVE ANY OF THE FOLLOWING?**

Headaches Yes No Have you been diagnosed with cancer? Yes No

Dizziness Yes No What type? \_\_\_\_\_

Blackouts Yes No Have you had radiation or chemotherapy treatments? Yes No

Seizures Yes No Last treatment date: \_\_\_\_\_

History of stroke Yes No Have you ever had a Liver Transplant? Yes No

Hypertension Yes No Have you ever been diagnosed with severe Hepatic Disease? Yes No

Diabetes Yes No

Please list any medical conditions: \_\_\_\_\_

Please list any medication allergies: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*I attest that the above information is correct to the best of my knowledge.*
**TO BE COMPLETED BY DEPARTMENTAL STAFF**

Exam: \_\_\_\_\_ Reason for exam: \_\_\_\_\_

Contrast type: \_\_\_\_\_ Amount/Rate: \_\_\_\_\_ Site: \_\_\_\_\_

 Technologist: \_\_\_\_\_ Date: \_\_\_\_\_ # of Images: \_\_\_\_\_ GFR: \_\_\_\_\_ mL/min/1.73m<sup>2</sup>

Creatinine: \_\_\_\_\_ Reference Range: .6-1.5 mg/dl