

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?
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

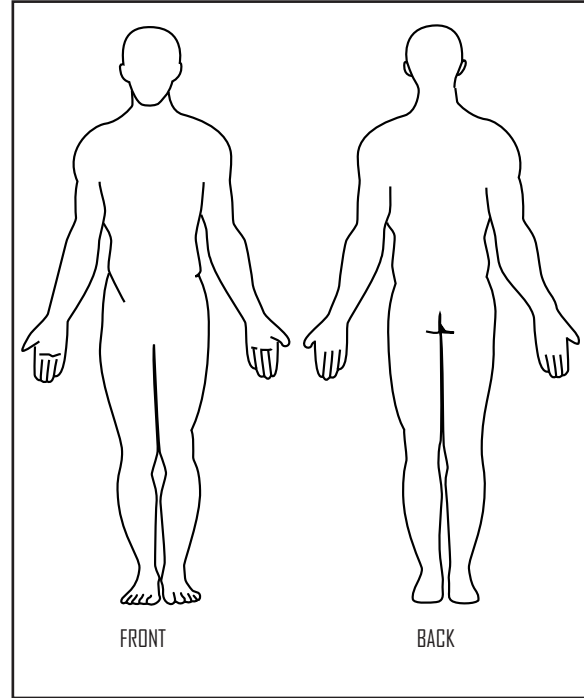
Is this procedure being done due to an automobile accident? Yes No

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/1.73m²

Creatinine: _____ Reference Range: .6-1.5 mg/dl