Premier Diagnostic Imaging **MRI Questionnaire**

Name ______________________________ MRN# __________________ Date ____/____/_______

Date of Birth ___/___/______ Male ___ Female ___ Age_____ Height_____ Weight _____

Reason for MRI and/or Symptoms ____

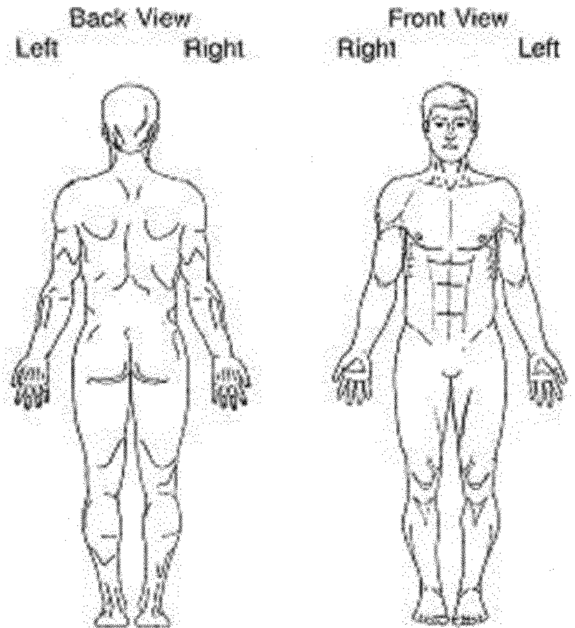
1. Please list every surgery you have ever had :
   Type of surgery ____________ Date __/__/____ Type of surgery ____________ Date __/__/____
   Type of surgery ____________ Date __/__/____ Type of surgery ____________ Date __/__/____
   Type of surgery ____________ Date __/__/____ Type of surgery ____________ Date __/__/____
2. Are you allergic to any medications? Yes ___ No ___
   If yes, please describe: ____
3. Have you ever experienced any problem related to a previous MRI exam or had a gadolinium contrast reaction?
   If yes, please describe: ____
4. Do you have a history of Renal (Kidney) disease, asthma, allergic reactions, respiratory disease, or reaction to contrast medium (or dye) used for an MRI, CT, or XRay exam ? Yes __ No ___ If yes, Please circle all that apply.
5. Are you currently taking or have you recently taken any medication or drug? Yes___ No ___
   If yes, please list ____
6. Have you had an injury to the eye involving a metallic object or fragment (eg. Metallic slivers, shavings, or foreign body)?
   If yes, please describe: ____

Carefully answer YES or NO to *ALL* the following items. Certain implants, devices, or foreign objects in your body may interfere with the exam and be hazardous to your safety.

DO YOU HAVE:

☐ Yes	☐ No	**Aneurysm clip(s)**
☐ Yes	☐ No	**Cardiac Pacemaker**
☐ Yes	☐ No	**Implanted Cardiac Defibrillator (ICD)**
☐ Yes	☐ No	**Internal Electrodes or Wires**
☐ Yes	☐ No	Electronic, Magnetically-activated Implant or Device
☐ Yes	☐ No	Neurostimulator or Biostimulator System
☐ Yes	☐ No	Spinal Cord Stimulator
☐ Yes	☐ No	Cochlear, Otologic, or other Ear Implant
☐ Yes	☐ No	Insulin or other medication Infusion Pump
☐ Yes	☐ No	Any type of Prosthesis (Heart,Eye, Penile, etc.)
☐ Yes	☐ No	Eyelid Spring or Wire
☐ Yes	☐ No	Artificial or Prosthetic Limb
☐ Yes	☐ No	Metallic Stent, Filter, or Coil
☐ Yes	☐ No	Shunt (Spinal or Intraventricular)
☐ Yes	☐ No	Vascular Access Port and/or Catheter
☐ Yes	☐ No	Radiation Seeds or Implants
☐ Yes	☐ No	Medication Patch (Nicotine, Analgesic, Nitroglycerine)
☐ Yes	☐ No	Any Metallic Fragment or Foreign Body
☐ Yes	☐ No	Tissue Expander (Breast)
☐ Yes	☐ No	Surgical Staples, Clips, or Metallic Sutures
☐ Yes	☐ No	Bone/Joint Pin, Screw, Nail, Wire, or Prosthesis
☐ Yes	☐ No	IUD, Diaphragm or Pessary
☐ Yes	☐ No	Dentures or Partial Plates
☐ Yes	☐ No	Tattoo or Permanent Makeup
☐ Yes	☐ No	Body Piercing Jewelry
☐ Yes	☐ No	Hearing Aid
☐ Yes	☐ No	Any Implanted Medical Object/Device

Please mark on this drawing the location of any metal inside your body, or site of Surgical operation.



I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form. I have had the opportunity to ask questions regarding the information on this form and the MR procedure that I am about to undergo.

Signature of Person Completing Form: ______________________ Date: ___/___/______
Signature

Form Completed By: ☐ Patient ☐ Relative ☐ Nurse ______________________ ______________________
Print Name Relationship to Patient

Signature of Spouse or Guardian: ______________________ Date: ___/___/______
Signature

Signature of PDI Employee Reviewing Form: ______________________