

# 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. Have you had an injury to the eye involving a metallic object or fragment (eg. Metallic slivers, shavings, or foreign body)?

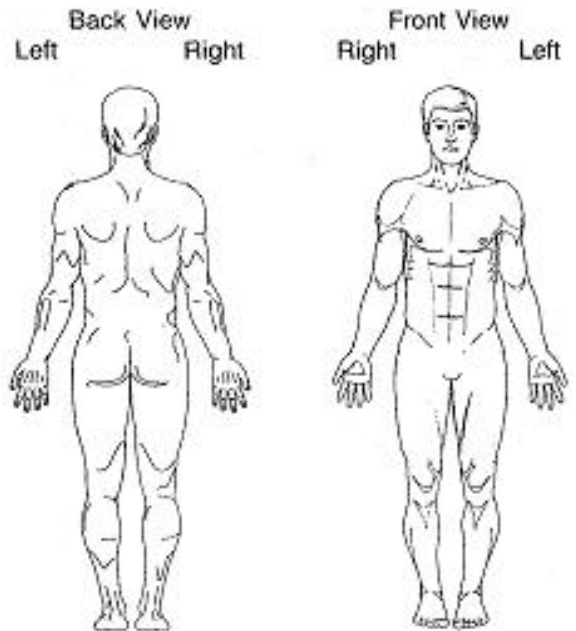
If yes, please describe: \_\_\_\_\_

**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:**

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

Form Completed By:  Patient  Relative  Nurse \_\_\_\_\_  
Signature Print Name Relationship to Patient

Signature of Spouse or Guardian: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature

Signature of PDI Employee Reviewing Form: \_\_\_\_\_