THE IMAGECARE CENTERS

MRI QUESTIONNAIRE

Name: _____ DOB:_____ Date:_____

Type of MRI/MRA (body part):_____

Referring Doctor:_____ Weight:_____ Height:_____

1. Have you ever been a metal worker, machinist or cut or grind any metal? **YES NO**

   If yes, did you wear protective eye covering? **YES NO**

   Have you ever had a penetrating eye injury? **YES NO**

2. Is there any possibility that you are pregnant? **YES NO**

   Last Period:_____

3. Are you breastfeeding? **YES NO**

4. Do you wear a transdermal patch (nicotine or pain patch) **YES NO**

5. Are you wearing "magneto" or magnetic gel-nail polish? **YES NO**

6. Do you have a PACEMAKER? **YES NO**

Please describe your present symptoms/ Reason for today's exam:

_____

_____

Please list other diagnostic tests relating to this problem: _____

_____

_____

List any surgery you have had: _____

_____

_____

Do you have:

Cerebral Aneurysm Clips	YES	NO	Date Implanted:_____
Abdominal Aneurysm	YES	NO	Date Implanted:_____
Pacemaker	YES	NO	Date Implanted:_____
Defibrillator	YES	NO	Date Implanted:_____
Tissue Expander	YES	NO	Date Implanted:_____
IUD	YES	NO	Date Implanted:_____
Shrapnel (bullets)	YES	NO	Date Implanted:_____
Stents	YES	NO	Date Implanted:_____
Any Metal Implant	YES	NO	Date Implanted:_____
Heart Valve	YES	NO	Date Implanted:_____
Neuro Stimulator	YES	NO	Date Implanted:_____
Hearing Aid	YES	NO	Date Implanted:_____
Cochlear Ear Implant	YES	NO	Date Implanted:_____
Shunt	YES	NO	Date Implanted:_____
Portacath	YES	NO	Date Implanted:_____
Any other metals	YES	NO	Date Implanted:_____
Greenfield Filter (IVC)	YES	NO	Date Implanted:_____
Renal Failure/Disease	YES	NO	

Patient Signature:_____ **Date**:_____