IMAGECARE RADIOLOGY

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. Do you have any cosmetic tattoos? **YES NO**
4. Are you breastfeeding? **YES NO**
5. Do you wear a transdermal patch? **YES NO**

   (nicotine or pain patch)
6. Are you wearing "magneto" or magnetic gel-nail polish? **YES NO**
7. Do you have a PACEMAKER? **YES NO**

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

____

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Please list other diagnostic tests relating to this problem: ________

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____

List any surgery you have had: ____________________

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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	

Is this test related to a motor vehicle accident or slip and fall that is currently under litigation or may be in litigation in the future? **YES NO

Is this test related to a workman's compensation claim? **YES NO

Patient Signature:______________________________ Date:____________