MRI Questionnaire (Prostate Only)

Name:_____ Date of Birth:_____ Date: _____

Referring Doctor:_____ Weight:_____ Height:_____

Have you ever been a metal worker,	**YES**	**NO**
If yes, did you wear protective eye covering?	**YES**	**NO**
Have you ever had a penetrating eye injury?	**YES**	**NO**
Do you have any cosmetic tattoos?	**YES**	**NO**
Do you wear a transdermal patch? (*nicotine or pain patch*)	**YES**	**NO**
Are you wearing "magneto" or magnetic gel-nail polish?	**YES**	**NO**

List any surgery you have had:_____

Please list other diagnostic tests relating to this problem: _____

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

Do you have:

Pacemaker	**YES**	**NO**	
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**

IMAGECARE RADIOLOGY

PINK BREAST CENTER

MRI Questionnaire (Prostate Only)

Do you have a diagnosis of prostate cancer? **YES** **NO**

If yes:

When were you diagnosed: _____

Where was the biopsy performed: _____

Has your doctor told you that your PSA is rising? **YES** **NO**

Have you had any of the following treatments (*circle all that apply*):

Prostatectomy When: _____

Hospital: _____

Surgeon: _____

Radiation seeds When they were put in: _____

Who put them in: _____

External beam radiation Last treatment: _____

Hormone therapy Are you currently taking hormones? **YES** **NO**

Other treatments: _____

_____

If no :

How many biopsies have you had: _____

Where: _____

Date of last biopsy: _____

Is your PSA Rising? **YES** **NO**

Do you know your most recent PSA? _____

Have you had a prior Prostate MRI? **YES** **NO**

When: _____

Where: _____

Patient Signature: _____ **Date:** _____