MRI Patient Questionnaire

Your Name:____________________________  Age____Weight____ lbs  Sex M F

SOME PEOPLE CANNOT HAVE AN MRI EXAM, THEY CANNOT GO NEAR THE MRI SCANNER

Do you have (or ever had) any of the following?

Y N  A medical device in your body such as a pacemaker
Y N  Surgical aneurysm clip in the brain
Y N  Metal fragments (or rust) in the eye
Y N  Have you ever worked in a machine shop or similar environment where you may have been subjected to small metal slivers, particularly in the eyes?
Y N  Any other metal or object in your body (shunt, stent) _________________
Y N  Nerve or bone stimulator
Y N  Drug infusapump
Y N  Eye or ear implant
Y N  Transdermal patches i.e.: nitroglycerin, nicotine, HRT/tattoo
Y N  Are you pregnant or nursing?  When was your last menstrual period _____
Y N  IUD

Please describe in your own words your present complaint of problem.  How long ago did it start?

What does your doctor think is the cause? _____________________________________________
______________________________________________________________________________

Are you here as a result of a CAR ACCIDENT?  Y        N  WORK ACCIDENT Y        N

If yes, please give us date of accident ____________/______/_______

Please check all of the diseases in this list that you have either had in the past – or for which you are now under treatment:

___ High blood pressure  ___ Cancer*(specify below)  ___ Diabetes
___ Heart disease    ___ Hereditary disease*  ___ Immune Deficiency
___ Surgery on head* ___ Asthma     ___ Pituitary/Hormone disease
___ Stroke/bleeding in brain ___ Multiple sclerosis  ___ Epilepsy
___ Sickle cell disease ___ Physical therapy  ___ Allergies; If yes please list
___ Previous surgeries

______________________________________________________________________________

Have you eaten anything in the last four hours?  Y N

Do you have any of the following signs/symptoms or have you had any of the following treatments?  
(Please check all that apply):

___ Difficulty walking  ___ Difficulty speaking  ___ Physical therapy
___ Paralysis/weakness of ___ Fever, night sweats  ___ Previous MRI
any body part    ___ Radiation  ___ Previous Gadolinium injection
___ New onset seizures ___ Claustrophobia ___ Previous exam for this complaint-
___ Problems with vision or hearing ___ Dizziness  X-RAY-US-CT

Shade figures below to highlight areas of pain or discomfort.

ANTERIOR

POSTERIOR

RIGHT LEFT LEFT RIGHT

To the best of my knowledge the above information is true and correct.

Signed Patient _____________________________ Date __________________

Signed Interviewer __________________________ Date __________________