



Imaging Services

**MAGNETIC RESONANCE IMAGING (MRI) QUESTIONNAIRE –
OUTPATIENT**
Instruction:

To be completed by patient prior to MRI.

Side 1 of 2

 Sex: Male Female Age: _____ Estimated weight: _____ Estimated height: _____

Reason for MRI and/or symptoms: _____

Referring/ordering physician: _____



WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MRI procedure. Do not enter the MRI system room or MRI environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist BEFORE entering the MRI room. The MRI Magnet is ALWAYS on.

Do you have, or have you had any of the following:

- | | | | | | |
|------------------------------|-----------------------------|--|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cardiac pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vascular access port and/or catheter |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted cardioverter defibrillator (ICD) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation seeds or implants |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aneurysm clip(s) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swan-Ganz or thermodilution catheter |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Brain surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Skin patch (e.g., Nicotine, Nitroglycerine, pain) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Electronic implant or device | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any metallic fragment or foreign body |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Magnetically-activated implant or device | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Wire mesh implant |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neurostimulation system | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tissue expander (e.g., breast) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Spinal cord stimulator | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Surgical staples, clips, or metallic sutures |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Internal electrodes or wires | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Joint replacement (e.g., hip, knee) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone growth/bone fusion stimulator | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone/joint pin, screw, nail, wire, plate |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cochlear, otologic, or other ear implant | <input type="checkbox"/> Yes | <input type="checkbox"/> No | IUD, diaphragm, or pessary |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Insulin or other infusion pump | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dentures, or partial plates |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted drug infusion device | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Color contact lenses |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any type of prosthesis (e.g., eye, penile) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tattoo or permanent makeup |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart valve prosthesis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Body piercing jewelry |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eyelid spring or wire | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing aid |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial or prosthetic limb | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other implant: _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Metallic stent, filter, or coil | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Breathing problem or motion disorder |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shunt (e.g., spinal, intraventricular) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Claustrophobia |

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy) of any kind?

 Yes No If yes, please indicate the date and type of surgery:

Date: _____ Type of surgery: _____

Date: _____ Type of surgery: _____

2. Have you had a prior diagnostic imaging study or examination of the same body part we are imaging today (MRI, Computerized tomography (CT), Ultrasound, X-ray, etc.)?

 Yes No If yes, list: _____

 3. Have you ever done any sheet metal/welding work? Yes No

 If yes, did you always wear eye protection? Yes No

 4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? Yes No

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?

 Yes No If yes, describe: _____

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OUTPATIENT**

Side 2 of 2

6. Are you pregnant or possibly pregnant? Yes No
7. Are you breastfeeding? Yes No
8. Are you allergic to any medications?
 Yes No If yes, list and describe reaction: _____
9. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? Yes No If yes, describe: _____
10. Do you have anemia or any disease(s) that affects your blood, a history of kidney disease, kidney failure, kidney transplant, high blood pressure (hypertension), liver disease, a history of diabetes, or seizures?
 Yes No If yes, describe: _____

Please complete the following section ONLY if you are scheduled for an MRI of head or spine. If not, proceed to signature portion at the bottom of page.

1. Have you ever had radiation treatments? Yes No
2. Have you ever had chemotherapy? Yes No
3. Do you have headaches? Yes No
4. Do you have memory loss? Yes No
5. Do you have trouble walking? Yes No
6. Do you have dizziness? Yes No
7. Do you have blurry vision? Yes No

If you have any of the following, please mark:	Yes	No	If yes, which side:		
			Right	Left	Both
Facial pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial numbness/paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arm pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arm tingling/numbness/weakness/paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg tingling/numbness/weakness/paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: You will be required to wear earplugs or other hearing protection during the MRI procedure to prevent problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MRI procedure that I am about to undergo.

Signature of Patient/Representative Relationship to Patient Date / / Time _____