CHRISTIANA CARE
HEALTH SERVICES

XRAYCLD

Imaging Services

MAGNETIC RESONANCE IMAGING (MRI) QUESTIONNAIRE – OUTPATIENT

Name:

Date of birth:

Instruction:
To be completed by patient prior to MRI.

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

Reason for MRI and/or symptoms: _____

_____

_____

Referring/ordering physician: _____

Other physician needing reports: _____

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:

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

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) 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

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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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	☐	☐	☐	☐	☐
Facial numbness/paralysis	☐	☐	☐	☐	☐
Hearing loss	☐	☐	☐	☐	☐
Vision loss	☐	☐	☐	☐	☐
Neck pain	☐	☐	☐	☐	☐
Arm pain	☐	☐	☐	☐	☐
Arm tingling/numbness/weakness/paralysis	☐	☐	☐	☐	☐
Back pain	☐	☐	☐	☐	☐
Leg pain	☐	☐	☐	☐	☐
Leg tingling/numbness/weakness/paralysis	☐	☐	☐	☐	☐

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