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
___Heart disease
___Surgery on head*
___Stroke/bleeding in brain
___Sickle cell disease
___Cancer*(specify below)
___Hereditary disease*
___Asthma
___Multiple sclerosis
___Physical therapy
___Previous surgeries
___Diabetes
___Immune Deficiency
___Pituitary/Hormone disease
___Epilepsy
___Allergies; If yes please list _____

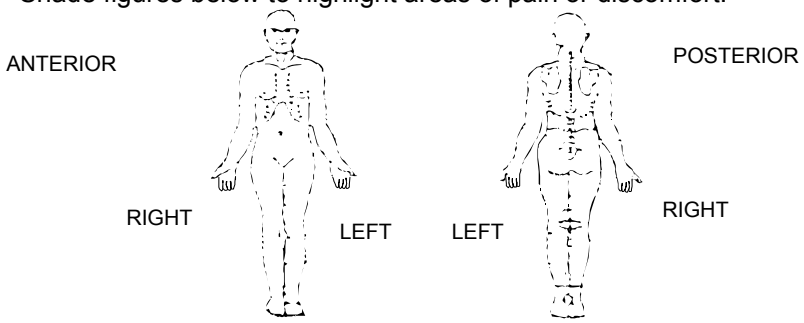
_____

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
___Paralysis/weakness of any body part
___New onset seizures
___Problems with vision or hearing
___Difficulty speaking
___Fever, night sweats
___Claustrophobia
___Dizziness
___Physical therapy
___Previous MRI
___Radiation
___Previous Gadolinium injection
___Previous exam for this complaint- X-RAY-US-CT

Shade figures below to highlight areas of pain or discomfort.



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

Signed Patient _____ Date _____

Signed Interviewer _____ Date _____