MRI Patient Questionnaire & History Form

Last Name _____ First Name _____ M.I. ____

Appointment Date _____ Location _____

YYYY-MM-DD

Date of Birth _____ Weight _____ lbs. Most recent serum creatinine _____

What kind of problems are you having related to today's exam?

Do you have a personal history of any type of cancer? ..... ◯Yes ◯No

- *If yes, what type?* _____

Have you ever had surgery on the area being examined today? ..... ◯Yes ◯No

- *If yes, please provide date:* _____ *and type of surgery:* _____

Have you ever had a prior MRI on the area being examined today? ..... ◯Yes ◯No

- *If yes, please provide date:* _____ *and facility:* _____

Have you ever had an injury to the eye involving a metallic object or metallic slivers? ..... ◯Yes ◯No

- *If yes, please notify MRI staff **NOW!***

Do you have any drug allergies? ..... ◯Yes ◯No

- *If yes, please list* _____

Have you ever had a reaction to the MRI or CT contrast? ..... ◯Yes ◯No

Do you or have you ever been told you have renal disease or are you on dialysis? ..... ◯Yes ◯No

- *If yes, what was your most recent serum creatinine level?* _____

Have you recently (within the last year) had an organ transplant, have you been diagnosed with liver failure, or are you on a liver transplant waiting list? ..... ◯Yes ◯No

Are you pregnant, think you might be pregnant, or are you currently breastfeeding? ..... ◯Yes ◯No

Please check if you have any of the following:

Cardiac Pacemaker? ..... ◯Yes ◯No

- *If yes, please notify MRI staff **NOW!***

Cardiac Stent or any type of stent? .... ◯Yes ◯No

Cardiac pacer or lead wire? ..... ◯Yes ◯No

Heart valve prosthesis? ..... ◯Yes ◯No

Any type of surgical clip or staples? ... ◯Yes ◯No

Any type of intravascular coil, filter, or stent? (IVC filter, Gianturco coil, etc.) ..... ◯Yes ◯No

Implanted insulin pump? ..... ◯Yes ◯No

Any type of electronic or mechanical implant? ..... ◯Yes ◯No

- *Type:* _____

Implanted drug infusion device? ..... ◯Yes ◯No

Penile Implant? ..... ◯Yes ◯No

- *Make or Model:* _____

Claustrophobic? ..... ◯Yes ◯No

Any type of internal electrode, including cochlear (ear) implant? ..... ◯Yes ◯No

Vascular access port? ..... ◯Yes ◯No

Intracranial aneurysm clip? ..... ◯Yes ◯No

Any type of implant held in place by magnent? Dentures? ..... ◯Yes ◯No

Intraventricular shunt? ..... ◯Yes ◯No

Hearing aid?..... ◯Yes ◯No

Orbital/eye prosthesis? ..... ◯Yes ◯No

Artificial limb or joint? ..... ◯Yes ◯No

Wire mesh? ..... ◯Yes ◯No

Body piercing or tattooed eyeliner? ... ◯Yes ◯No

Any type of implanted orthopedic item such as pins, screws, nails, etc? .. ◯Yes ◯No

- *Type:* _____

Are you wearing a transdermal patch? ◯Yes ◯No

Any other implanted item? ..... ◯Yes ◯No

_____ Signature of person providing information

_____ Relationship to Patient *(if other than patient)*

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