MRI QUESTIONNAIRE

Premier Diagnostic Imaging
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PLEASE COMPLETE ENTIRE FORM FRONT AND BACK.

OFFICE USE ONLY
MRN #

PATIENT INFORMATION

Name: _____

Date of Birth: _____ ❑ Male ❑ Female

Height: _____ Weight: _____

REASON FOR MRI AND/OR SYMPTOMS

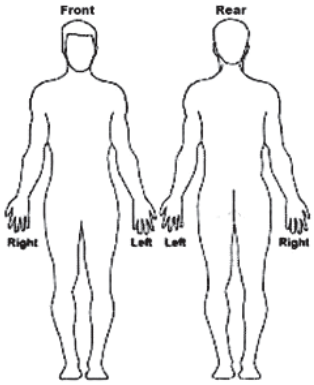
_____

_____

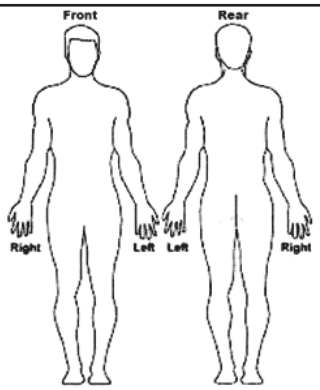
_____

Where are your symptoms?

X = Where you hurt most
A = Aching
W = Weakness
N = Numbness
P = Pins/needles
S = Stabbing
B = Burning
O = Scar



Please mark on this drawing the location of any metal inside your body, or site of Surgical operation.



1. Please list any type of surgery you have ever had:
   Type of Surgery _____ Date ___/___/___ Type of Surgery _____ Date ___/___/___
   Type of Surgery _____ Date ___/___/___ If you have had additional surgeries, please list on back side.
2. Are you allergic to any medications? Yes___ No___ If yes, please describe: _____
   (If additional space is needed, please list on back side.)
3. Do you have a history of Diabetes or High Blood Pressure? Yes ____ No ____ If yes, please describe: _____
4. Have you ever experienced any problem related to a previous MRI exam such as claustrophobia; or had a gadolinium reaction to MRI contrast agent/dye? Yes___ No___ If yes, please describe: _____
5. Do you have a history of Renal (Kidney) disease, asthma, allergic reactions or respiratory disease? Yes____ No____
6. Have you had an injury to the eye involving a metallic object or fragment (eg. Metallic slivers, shavings, or foreign body)? Yes_____ No_____ If yes, please describe: _____

Carefully answer YES or NO to ALL of the following items. Certain implants, devices, or foreign objects in your body may interfere with the exam and be hazardous to your safety.

DO YOU HAVE:

- ☐ Yes ☐ No Aneurysm clip(s) or coil(s)
- ☐ Yes ☐ No Cardiac Pacemaker or Defibrillator (ICD)
- ☐ Yes ☐ No Internal Electrodes or Wires
- ☐ Yes ☐ No Internal/External Cardiac Monitor
- ☐ Yes ☐ No Medication Infusion Pump or Monitoring System
- ☐ Yes ☐ No Medication Patch, Monitoring Electrode, or Diabetes Monitor
- ☐ Yes ☐ No Any type implant held in place by a magnet
- ☐ Yes ☐ No Electronic, Magnetically-activated Implant or Device
- ☐ Yes ☐ No Neurostimulator or Biostimulator System
- ☐ Yes ☐ No Spinal Cord Stimulator
- ☐ Yes ☐ No Cochlear, Otologic, Ear, or Eye implants
- ☐ Yes ☐ No Hearing Aid (Please remove for exam)
- ☐ Yes ☐ No Eyelid Spring or Wire
- ☐ Yes ☐ No Artificial or Prosthetic Limb
- ☐ Yes ☐ No Metallic Stent, Filter, or Artificial Heart Valve

DO YOU HAVE:

- ☐ Yes ☐ No Watchman Device
- ☐ Yes ☐ No Shunt (Spinal or Intraventricular)
- ☐ Yes ☐ No Vascular Access port and/or Catheter
- ☐ Yes ☐ No Radiation Seeds or Implants
- ☐ Yes ☐ No Tissue Expander (Breast)
- ☐ Yes ☐ No Total Joint Replacement
- ☐ Yes ☐ No Surgical Staples, Clips, or Metallic Sutures
- ☐ Yes ☐ No Bone/Joint Pin, Screw, Nail, Wire, or Plate
- ☐ Yes ☐ No IUD, Diaphragm or Pessary
- ☐ Yes ☐ No Dentures or Partial Plates (Please remove for exam)
- ☐ Yes ☐ No Tattoo or Permanent Makeup
- ☐ Yes ☐ No Body Piercing Jewelry; Wig, or Hair Implants/Extensions
- ☐ Yes ☐ No Any Implanted Medical Object/Device _____
- ☐ Yes ☐ No Any type of Prosthesis (Heart, Eye, Penile, etc.)
- ☐ Yes ☐ No Recently Ingested Pill Camera
- ☐ Yes ☐ No Any Metallic Fragment or Foreign Body (Shrapnel, etc.)

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

Signature of Person Completing Form: _____ Date: _____

Form Completed By: ☐ Patient ☐ Relative ☐ Nurse / Print Name: _____ Relationship to Patient: _____

Signature of Tech Assistant Reviewing Form: _____ Date: _____

Signature of PDI Technologist Reviewing Form: _____ Date: _____

(See Back Page.)

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Continued from front side.

Additional surgeries not listed on the front of the form

Type of Surgery _____ Date ___/___/___ Type of Surgery _____ Date ___/___/___

Type of Surgery _____ Date ___/___/___ Type of Surgery _____ Date ___/___/___

Additional medicines you are allergic to: _____

_____

Instructions for the MRI Patient

Do not enter the MRI system room or MRI environment if you have any questions or concerns regarding an implant, device or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room.

1. Any medication patch or monitoring system must be marked on the front page of the screening form. The MRI technologist will discuss with patient prior to MRI.
2. Remove all jewelry, and lock it in the locker provided for you.
(Ex. necklaces, pins, rings)
3. Remove all hair pins, bobby pins, barrettes, clips, and lock them in the locker provided for your use.
4. Wigs will need to be removed just prior to going in the scan room.
5. Remove all dentures, false teeth, and partial dental plates prior to the MRI.
6. Lock the following items in the locker provided for you: (wallet, purse, watch, pager, cell phone).
7. Remove all body piercing jewelry and lock them in the locker provided for your use.
8. Remove hearing aides just prior to going in the scan room. This will enable us to still communicate well during the interview process.
9. FEMALES: You are required to remove your Bra/Sports Bra due to the metal clips, underwire, or certain fabrics that will cause burns or artifacts with your images.
Extra gowns can be provided upon request.
10. Let the technologist know if this is a follow-up to a previous test performed at Premier, or another medical facility.
11. You will be instructed to use the ear plugs or headphones we supply during your MRI examination as a hearing protective device as loud noises are generated during the MR procedure.