



MRI QUESTIONNAIRE

Name: _____ Date of birth: _____

Age: _____ Height: _____ Weight: _____ Sex: M F

Referring physician: _____

What type of exam are we doing today? _____

What types of problems are you having? _____

Have you been diagnosed with cancer? yes no

If yes, explain _____

Have you had surgery on the area being scanned? yes no

If yes, explain _____

Have you had recent x-rays, CT or MRI scans of area being scanned? yes no

Location? _____

Are you pregnant or nursing? yes no

Do you have history of kidney disease or diabetes? yes no

Are you claustrophobic? yes no

Have you been given sedation for this exam? yes no

Please check appropriate box for each of the following:

- yes no cardiac pacemaker or defibrillator
- yes no heart valve replacement surgery
- yes no brain surgery / aneurysm clips
- yes no medicine patches (with foil backing)
- yes no cochlear implants
- yes no neurostimulator
- yes no insulin pump or infusion pump
- yes no metal implants or metal fragments
- yes no artificial limbs or body braces

*****Please remove dental partials, hearing aides and jewelry before scan.*****

I acknowledge that all the information given is accurate and thereby consent to have Magnetic Resonance Imaging performed on me. I also consent to the use of IV MRI contrast if needed to aid in the evaluation of the study.

Patient signature: _____ Date: _____

IV contrast: Multihance or Prohance ML's used: _____ ML's discarded: _____

Needle size: _____ g Site: _____ IV by: _____

Creatinine: _____ Date drawn: _____ Location: _____

Notes: _____

Technologist signature: _____ Date: _____