

MRI QUESTIONNAIRE

APPOINTMENT DATE: _____ **APPT. TIME** _____ **ARRIVAL TIME:** _____
Do You Have A Follow-up Appt. with your Doctor? _____ **When?** _____

Patient's Name _____ **DOB** _____ (Circle) Male/Female

Type of Scan _____ **R/O** _____ **Height** _____ **Weight** _____

Referring Physician _____ **Phone #** _____

SAFETY QUESTIONS	
Do you have a Pacemaker/Defibrillator	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Do you have aneurysm clips	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Have you ever had metal go into or removed from your eyes	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Are you a welder, sheet metal worker or grind with metal	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Have you ever had any <input type="checkbox"/> BRAIN <input type="checkbox"/> HEART <input type="checkbox"/> EAR/EYE surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Have you had any surgery or procedure that left any device, implant, stents, wires or stimulators in your body	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A WHERE: _____
Do you have a tissue expander implanted	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Do you have removable dentures or hearing aids	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Do you have any tattoo eyeliner	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Are you wearing any medicated patches	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Do you have any metal or mechanical devices hooked up or inside of you	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Are you pregnant	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Can you walk without assistance	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A EXPLAIN _____

CLINICAL QUESTIONS

Have you had any previous exams of the same body part? **OBTAIN REPORT**	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A Yes, Where/When: _____
Have you had SURGERY of the body part we are scanning today If YES, what type: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Do you or have you ever had any type of Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A Yes, What: _____

CONTRAST QUESTIONS

****PATIENTS NEED TO DRINK AT LEAST 2 8OZ GLASSES OF WATER PRIOR TO EXAM****

Have you had MRI Contrast (Injection) before	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A Yes, please list any allergic occurrence: _____
Have you been diagnosed with Kidney disease or Kidney failure	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Are you on Dialysis (If so Patient MUST schedule Dialysis after Scan)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
Are you Diabetic	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A

****Any patient with diabetes, kidney failures or over 60 must have blood work. (Labs: BUN, GFR, Creatinine)****

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 I have reviewed the above information provided in the telephone screening, and it is correct. I hereby give permission to Middletown Medical Imaging to perform this MRI exam.

Patient/Guardian Signature: _____ **Date:** _____

Attachments: Prior Exam Blood work Script

Front Desk Only: Date: _____ **CONFIRMED** **LEFT MESSAGE** **NO ANSWER**

For Contrast studies: **instructed patient to drink water**