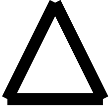
MRI HISTORY QUESTIONNAIRE

Date______________________________Weight of Patient_________________Gender______________________________

Ordering MD__________________________________Exam Requested____

Diagnosis____

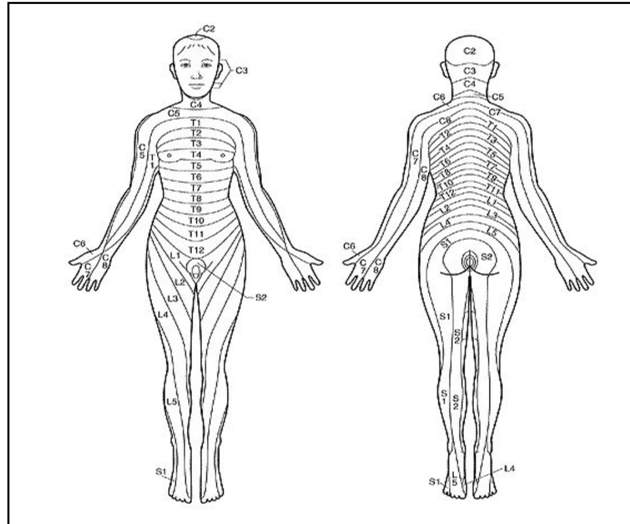


WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. **The MR system magnet is ALWAYS on.**

Please indicate if you have any of the following:

YES	NO	
❑	❑	**Aneurysm clip(s)**
❑	❑	**Cardiac pacemaker**
❑	❑	**Implanted cardioverter defribrillator (ICD)**
❑	❑	**Electronic implant or device**
❑	❑	**Magnetically-activated implant or device**
❑	❑	**Neurostimulation system**
❑	❑	**Spinal cord stimulator**
❑	❑	**Internal electrodes or wires**
❑	❑	**Bone growth/bone fusion stimulator**
❑	❑	**Cochlear, otologic, or other ear implant**
❑	❑	**Insulin or other infusion pump**
❑	❑	**Implanted drug infusion device**
❑	❑	**Any type of prosthesis (eye, penile, etc.)**
❑	❑	**Heart valve prosthesis**
❑	❑	**Eyelid spring or wire**
❑	❑	**Artificial or prosthetic limb**
❑	❑	**Metallic stent, filter or coil**
❑	❑	**Shunt (spinal or intraventricular)**
❑	❑	**Vascular access port and/or catheter**
❑	❑	**Radiation seeds or implants**
❑	❑	**Swan-Ganz or thermodilution catheter**
❑	❑	**Medication patch (Nicotine, Nitroglycerine)**
❑	❑	**Any metallic fragment or foreign body**
❑	❑	**Wire mesh implant**
❑	❑	**Tissue expander (e.g., breast)**
❑	❑	**Surgical staples, clips, or metallic sutures**
❑	❑	**Joint replacement (hip, knee, etc.)**
❑	❑	**Bone / joint pin, screw, nail, wire, plate, etc.**
❑	❑	**IUD, diaphragm, or pessary**
❑	❑	**Dentures or partial plates**
❑	❑	**Tattoo or permanent makeup**
❑	❑	**Body piercing jewelry**
❑	❑	**Hearing aid** *(Remove before entering MR system room)*
❑	❑	**Other implant** ____________________________
❑	❑	**Breathing problem or motion disorder**
❑	❑	**Claustrophobia**

PLEASE MARK ON THE FIGURE(S)



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove ALL metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners and clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

Any YES answers please Inform Technologist

MRI HISTORY QUESTIONNAIRE

What are your symptoms?____

Were you injured? ❑ Yes ❑ No If Yes, How & When?______________________________

What date did your problem begin?______________________________________

Have you had surgery for this problem? ❑ Yes ❑ No If Yes, Date of Surgery:_______________

Have you had therapy for this problem? ❑ Yes ❑ No If Yes, Please Describe:_______________

____

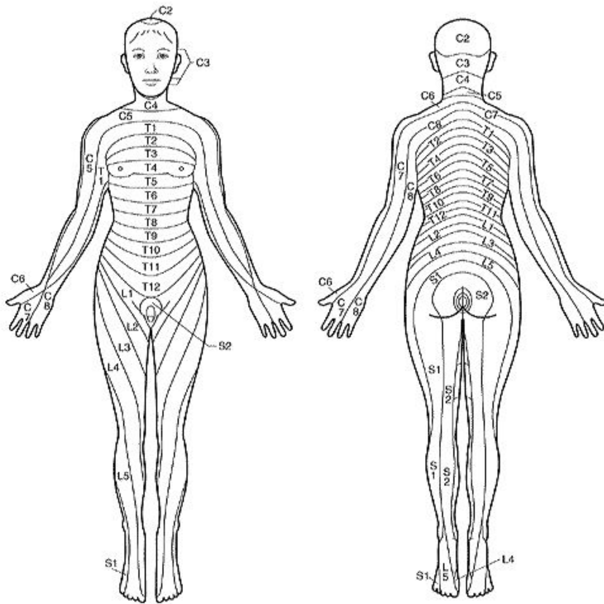
Do you have or have you ever had any of the following?

Diabetes	❑ Yes ❑ No	Sickle Cell	❑ Yes ❑ No	
High Blood Pressure	❑ Yes ❑ No	Cancer	❑ Yes ❑ No	If Yes, What Type?__________
Anemia	❑ Yes ❑ No			

Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ❑ Yes ❑ No

If yes, please list:	BODY PART	DATE	FACILITY
MRI	______________	____/____/____	______________
CT/CAT Scan	______________	____/____/____	______________
X-Ray	______________	____/____/____	______________
Ultrasound	______________	____/____/____	______________
Nuclear Medicine	______________	____/____/____	______________
Other __________	______________	____/____/____	______________

Please shade in areas of pain, weakness, and/or numbness on the following diagram:



IV ACCESS:
INT__________ga.

SITE:____________
____
____
IV D/Cd__________
INITIALS__________

____
Signature of Patient

______________________________ ______________________________
Signature of Legal Representative **Relationship to Patient**

______________________________ ______________________________
Signature of Staff Member **Date/Time**

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MRI HISTORY QUESTIONNAIRE
UNION GENERAL HOSPITAL
BLAIRSVILLE, GA 30512
Form#0805 **Revised: 1/07**