MRI QUESTIONNAIRE

NAME: ___________________________________________ AGE: __________ D.O.B.: _______ M/F

HEIGHT: _______ WEIGHT: _______

Describe your symptoms and how long they have been present:____________________________________

__________________________________________________________________________________________

Did you have an injury? If so, please describe:____________________________________________________

__________________________________________________________________________________________

CIRCLE AFFECTED BODY PART: RIGHT / LEFT
KNEE  SHOULDER  WRIST  ANKLE  ELBOW  HAND  FOOT  ARM  LEG  OTHER___________________________

CIRCLE ANY THAT APPLY:
PRIOR SURGERY
INJURY
PAIN
SWELLING
JOINT LOCKS
JOINT GIVES WAY

PLEASE CHECK YES OR NO TO THE FOLLOWING QUESTIONS:
DO YOU NOW OR HAVE YOU EVER HAD:

1. A heart pacemaker? Yes__No__
2. Heart Valve? Yes__No__
3. Brain Surgery? Yes__No__
4. Aneurysm clips, vascular clips, intravascular filter, coil or stent? Yes__No__
5. Eye surgery or implant? Yes__No__
6. Ear surgery or implant? Yes__No__
7. Any type of implanted devices such as electrodes, TENS unit, neurostimulator, heart valve, mechanical or magnetic device? Yes__No__
8. Any metallic foreign body (shrapnel, bullet, bb pellet, etc…) Yes__No__
9. Have you ever had an eye injury caused by metal? Yes__No__
10. Have you ever been a metal worker, grinder, welder, machinist, etc… as a hobby or as a professional? Yes__No__
11. Are you wearing a hearing aid or dentures? Yes__No__
12. Have you ever been diagnosed as having cancer? Yes__No__
   if so, when and what type? __________________________________________
13. Do you have other medical problems that may be pertinent to and MRI exam? Yes__No__
   if so, please list them: __________________________________________

Female Patients Only:
Are you pregnant, or do you suspect that you could be pregnant? Yes__No__

DATE:_______________  SIGNATURE OF PATIENT: ____________________________________________