SUMMIT radiology

MRI PATIENT QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

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

Allergies: _____

List all previous surgeries: _____

_____

Do you have a return appointment scheduled with your doctor? _____

If yes, when and where? _____

Did you take any claustrophobia medication for your test today? _____

Please describe current symptoms you are having or have had: _____

WARNING: The MRI room contains a very strong magnet. Before you are allowed to enter we must know if you have any metal in your body. Certain implants, devices or objects may be hazardous to you or may interfere with the MRI procedure. PLEASE answer the following questions carefully.

Please indicate if you have any of the following:

YES	NO		YES	NO	
_____	_____	Stents	_____	_____	Brain Surgery
_____	_____	Aneurysm Clips	_____	_____	Blood Vessel Surgery
_____	_____	Ear Implants	_____	_____	Ear Surgery
_____	_____	Cardiac Valve Replacement	_____	_____	Hypertension/ High Blood Pressure
_____	_____	Dentures or Partials	_____	_____	History of metal shavings in the Face or Eyes
_____	_____	Hearing Aids (Please Remove)			
_____	_____	Neurostimulator	_____	_____	Shrapnel / Bullets / BB's
_____	_____	Vagus Nerve Stimulator	_____	_____	Any type of patch (pain, nicotine, birth control) Must be removed if it has a metal backing
_____	_____	Bone Growth Stimulator			
_____	_____	Pacemaker/ Defibrillator			
_____	_____	Breast Tissue Expander	_____	_____	Personal History of Cancer
_____	_____	Diabetes (glucose monitors must be removed)			Please list what type of cancer: _____
					Radiation? _____ Chemo? _____
_____	_____	Kidney Disease			
_____	_____	Implanted Pain Pump			Are You:
_____	_____	Insulin Pump	_____	_____	Pregnant
_____	_____	Any other Pumps	_____	_____	Possibly Pregnant
_____	_____	Joint Replacements	_____		Date of last menstrual period
_____	_____	Artificial Limbs			
_____	_____	Colonoscopy Clip			

_____ _____

Patient Signature **Print Name:**

_____ _____

Date **Relationship to patient (If patient is unable to sign or a minor)**

- - - - - - - - - - Below is for office use only -

MRI Technician signature : _____ Date: _____

Lot# _____ Exp: _____

GFR _____ Creatinine _____ NDC code _____

** The patient has been educated as to the nature, extent, and risks associated with this examination. ** _____