Radiology Department
Magnetic Resonance Imaging (MRI) Questionnaire

Name_____________________________________ Today’s date___________________
Date of Birth________________________ Age_________ Wt__________ Ht_________
Drug Allergies____________________________________________________________

Have you ever had previous back or neck surgery? If yes please indicate date of surgery and levels if known: _______________________________________________________
________________________________________________________________________

Please describe any other surgery or other tests you have undergone that relate to your current problem: __________________________________________________________

**Before having your MRI scan it’s important for us to know if:**
(Please Circle Yes or No)

- You have (or had) a heart pacemaker or defibrillator?.................................Yes No
- You have had intracranial surgery or aneurysm clips?.................................Yes No
- You have a nerve stimulator implant (T.E.N.S. Unit)?.................................Yes No
- You have had ear surgery (Cochlear Implant)?............................................Yes No
- You have any possibility of metal fragments or splinters in your eyes (including shrapnel and false eye)?.................................................................Yes No

*Metal fragments in the eye can cause serious and permanent eye injury during an examination!*

- You have a heart replacement valve?.............................................................Yes No
- You have metallic stents?................................................................................Yes No
- You have any electronic or orthopedic implants in your body?.......................Yes No
- You have a joint replacement, Harrington Rod, or surgical prosthesis in area to be scanned?.................................................................Yes No
- You have any metal part or foreign objects in your body?..............................Yes No
- You have a hearing aid?................................................................................Yes No
- You are diabetic?............................................................................................Yes No
- You have an infusion pump implant (insulin or medication)?........................Yes No
- You have received an IV iron treatment in the last 7 days?............................Yes No
- You are currently on renal dialysis or in renal failure or have kidney disease?....Yes No
- You have had a previous CT relating to current problem?..............................Yes No
- You have had a previous MRI relating to current problem?............................Yes No

When__________________ Where_________________

- You have a history of seizures?...................................................................Yes No
- You have permanent eyeliner, wig, hair piece or dentures?...........................Yes No
- You are pregnant or breast feeding?...............................................................Yes No
- You have or had any type of cancer?.............................................................Yes No

If yes, what area of the body_________________________________________________
DO NOT ENTER THE SCANNING ROOM WITH ANY OF THESE ITEMS

<table>
<thead>
<tr>
<th>Keys</th>
<th>Hearing Aid</th>
<th>Hairpins/barrettes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watch</td>
<td>Pocket Knife</td>
<td>Metal zippers/buttons</td>
</tr>
<tr>
<td>Glasses</td>
<td>Pens/pencils</td>
<td>Removable dental work</td>
</tr>
<tr>
<td>Earrings</td>
<td>Sanitary Belt</td>
<td>Wallet/money clip/coins</td>
</tr>
<tr>
<td>Permanent eye make-up</td>
<td>Underwire bra</td>
<td>Jewelry</td>
</tr>
<tr>
<td>Belt Buckle</td>
<td>Pagers/beepers</td>
<td>Magnetic strip cards</td>
</tr>
<tr>
<td>Safety Pins</td>
<td>Metal bra hooks</td>
<td>(credit cards/bank cards)</td>
</tr>
</tbody>
</table>

The above items, as well as any other metal, **may not** be taken into the magnet room. Damage to the equipment, MR system, and personal injury could result.

It is often necessary to administer an I.V. contrast to enhance a study for better results. I understand that a small risk is involved with this contrast. As with any I.V. injections, there is a chance for an allergic reaction to occur. If you have a renal disease there is an added risk that may cause a rare scleroderma-like skin disease called nephrogenic systemic fibrosis or nephrogenic fibrosing dermopathy. The benefits of this injection greatly out-weigh the risk involved.

I do hereby consent to the use of I.V. contrast media **if needed.**

I fully consent to having this MRI procedure performed at Tahlequah City Hospital

**I HAVE READ AND FULLY UNDERSTAND THIS QUESTIONNAIRE.**

**Signature_______________________________________________________________**

Ordering Physician_______________________ Region to be Examined______________

Clinical Information: ______________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Narrative Notes: __________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Reviewed by_____________________________________________________________