OFFICE USE ONLY:

ACCT #:_____

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**
When_____ Where_____
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

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

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 sclerodermalike 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_____