MRI PATIENT QUESTIONNAIRE

ID#_____________________________ **MRI FACILITY PH#** _____________________

Name: _______________________________

Referring Physician: _____________________________

Sex: ______ **Weight:** ______ **Age**_____ **Date of Birth** _________________

Allergies: ____

Prior surgeries:

____

Do you have a return appointment scheduled with your Doctor? _________________

If yes, When____

Please check each item or condition below as they apply to you.

Do you have:

YES	NO	
_____	_____	Aneurysm Clips
_____	_____	Ear Implants
_____	_____	Joint Replacements
_____	_____	Cardiac Valve Replacement
_____	_____	Artificial Limbs
_____	_____	Dentures or Partials
_____	_____	Hearing aids
_____	_____	Neurostimulator
_____	_____	Cardiac Pacemaker
_____	_____	Shrapnel / Bullets
_____	_____	Diabetes
_____	_____	Sickle Cell Anemia

Have you had:

YES	NO	
_____	_____	Brain Surgery
_____	_____	Vascular Surgery
_____	_____	Neck Surgery
_____	_____	Ear Surgery
_____	_____	History of Metal in the Face or Eyes
_____	_____	History of Cancer
_____	_____	Eyeliner Tattoos

Are You:

YES	NO	
_____	_____	Pregnant
_____	_____	Possibly Pregnant

_______________________________________ _________________________

Patient Signature **Imaging Center Witness**

____________________________________ __________________ ________________

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

PT. HISTORY:

This Patient has been Educated as to the Nature, Extent, and Risks Associated with this Examination._____________