



## MRI PATIENT QUESTIONNAIRE

THE FOLLOWING QUESTIONS ARE TO ASSURE YOUR SAFETY AND MAKE US AWARE OF ANY CONDITION THAT COULD INTERFERE WITH YOUR MRI STUDY. PLEASE ANSWER ALL QUESTIONS COMPLETELY.

Patient Name: \_\_\_\_\_ SMI ID # \_\_\_\_\_  
(FOR OFFICE USE)  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ DOB \_\_\_\_\_

**ATTENTION:** The following items are incompatible with a MRI exam. If you have any of the following items you **MUST** notify the receptionist and/or technologist immediately.

**PLACE A CHECK MARK NEXT TO ANY OF THE FOLLOWING ITEMS THAT YOU HAVE:**

- |                                                          |                                                                                         |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------|
| <input type="checkbox"/> Aneurysm clip in brain          | <input type="checkbox"/> Have done welding or metal work                                |
| <input type="checkbox"/> Artificial heart valve          | <input type="checkbox"/> Kidney disease                                                 |
| <input type="checkbox"/> Bullets or metal fragments      | <input type="checkbox"/> Hypertension                                                   |
| <input type="checkbox"/> Cardiac pacemaker               | <input type="checkbox"/> Diabetic                                                       |
| <input type="checkbox"/> Coronary artery stents          | <input type="checkbox"/> Allergy to dye/contrast                                        |
| <input type="checkbox"/> Dental implants                 | <input type="checkbox"/> Asthma                                                         |
| <input type="checkbox"/> Ear or eye lens implant         | <input type="checkbox"/> Insulin pump / drug pump                                       |
| <input type="checkbox"/> Implanted heart defibrillator   | <b><i>I DO NOT HAVE ANY OF THE ITEMS IN THIS SECTION:<br/>PLEASE INITIAL: _____</i></b> |
| <input type="checkbox"/> Implanted pacing leads or wires |                                                                                         |
| <input type="checkbox"/> Neurostimulator / Biostimulator |                                                                                         |

Please answer the following **completely**.

Previous MRI / CT / US Studies? (please list) \_\_\_\_\_

Are you Claustrophobic? Please circle one. YES or NO

Previous surgeries? (please list) \_\_\_\_\_

Implanted devices? (please list) \_\_\_\_\_

Medical history (family and personal) pertaining to your exam: \_\_\_\_\_

Please provide a summary of symptoms: \_\_\_\_\_

I certify that the above responses are correct to the best of my knowledge.

Signature: \_\_\_\_\_ date: \_\_\_\_\_

### **CONTRAST CONSENT:**

Your study may have been ordered by your physician to include an intravenous gadolinium injection, or our radiologist may feel that after reviewing your study and/or history you need to have an intravenous gadolinium injection, which will be performed by one of our certified technologists under the supervision of our ACLS certified technologist or radiologist. Please sign and date below.

SIGNATURE OF CONSENT: \_\_\_\_\_ DATE: \_\_\_\_\_