Open MRI Patient Questionnaire

Referring Physician's Name_____ Phone Number_____

Are you claustrophobic? Yes No Unsure (**Please Circle)** Please list the reason for the MRI:

_____

List your symptoms in **detail:** _____

How long have you had symptoms? _____ Are your symptoms the result of an injury? Yes or No **(Please Circle)** Date of Injury_____ Work related injury? _____ **&/OR** MVA (Motor Vehicle Accident)? _____ **Please list ALL PREVIOUS surgeries or arthroscopies**:

_____

_____

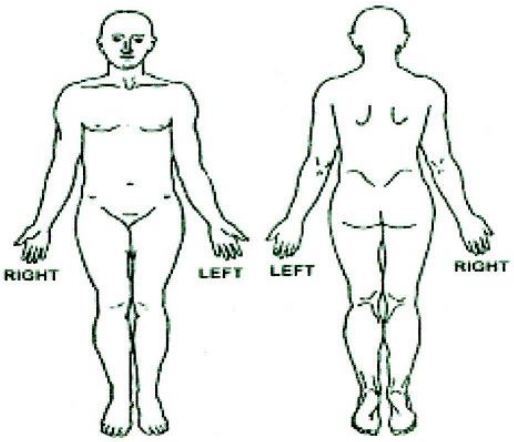
Have you had any Blood work in the Last 6 weeks? _____
Have you ever experienced any problem related to a previous MRI examination? _____
Have you ever had a reaction to MRI contrast? _____If so, please describe_____
Have you had any prior **related** diagnostic examinations? _____
If so, please list the: Body Part, Date & Facility_____

Please indicate if you have any of the following:

Yes No

- ❑ ❑ **Cardiac Pacemaker, wires, or defibrillator**
- ❑ ❑ **Do you have a history of ANY kidney disease?**
- ❑ ❑ **Are you on Dialysis?**
- ❑ ❑ **Do you have a history of Liver Failure or Cirrhosis?**
- ❑ ❑ **Do you have Diabetes?**
- ❑ ❑ **Do you have or are you currently being treated for High Blood Pressure/ Hypertension?**
- ❑ ❑ **Brain aneurysm clips**
- ❑ ❑ **Any vascular stents, filters, coils or artificial heart valves **Implant date of stent: _____**
- ❑ ❑ **Implanted drug infusion pump or insulin pump**
- ❑ ❑ **Implanted neurostimulator, spinal cord or bone stimulator**
- ❑ ❑ **Worked with metal?**
- ❑ ❑ **Had metal removed from eyes?**
- ❑ ❑ **Hearing Aid**
- ❑ ❑ **Eye implant, eyelid spring, retinal tack, or artificial eye**
- ❑ ❑ **Metal shrapnel, bullet, BBs, or pellets**
- ❑ ❑ **Any metallic fragment or foreign body**
- ❑ ❑ **Electronic or magnetically-activated implant or device**
- ❑ ❑ **Cochlear or other ear implant**
- ❑ ❑ **Are you pregnant or breastfeeding?**
- ❑ ❑ **Joint replacement or orthopedic hardware**
- ❑ ❑ **IUD, diaphragm, or pessary**
- ❑ ❑ **Any prosthesis or implant – Please List_____**
- ❑ ❑ **Medication Patch**
- ❑ ❑ **Magnetic dental implant**
- ❑ ❑ **Body piercing jewelry-(Other than ears)**
- ❑ ❑ **Tattoos or permanent makeup**
- ❑ ❑ **Personal History of Cancer? If so, what type?_____**
- ❑ ❑ **Asthma**
- ❑ ❑ **Sickle Cell Disease**

Please shade in the areas where you are having your pain or symptoms



I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form and the MRI procedure that I am about to undergo.

Patient's Name: _____ _____ DOB____/____/_____Weight_____
Print Name Signature

Signature of Person Completing Form**:** _____ Today's Date___/____/_____
Signature/Relationship

Form Information Reviewed By: Front Desk _____ Technologist _____