cape radiology group

MRI PATIENT QUESTIONNAIRE

_____

LAST FIRST MIDDLE

DATE OF BIRTH: _____ AGE: _____ MALE/FEMALE: _____ MRN: _____

REFERRING PHYSICIAN: _____

For Office Use Only:

DATE OF FOLLOW-UP: _____ FAX REPORT OR SEND DISC _____W/PATIENT _____OFFICE _____MAIL

PRIOR IMAGING RELATED TO EXAM: _____

SYMPTOMS: _____

_____

_____

_____

HAVE YOU HAD ANY SURGERIES? ..... YES/NO

LIST: _____

_____

_____

_____

1. Do you have a history of cancer? ..... YES/NO
   Explain:_____
2. Do you have any type of kidney disease/failure, asthma, diabetes, multiple myeloma, or hypertension with medical therapy? ..... YES/NO
   Explain:_____
3. Do you have drug allergies? ..... YES/NO
   List:_____
4. ***FEMALES only***_Are you pregnant or suspect pregnancy? ..... YES/NO
5. ***FEMALES only***_Are you breast feeding? ..... YES/NO
6. Do you consent to have contrast (gadolinium complex) injected when ordered by a physician? ..... YES/NO
7. Have you been given the **Medication Guide** for the IV contrast injection? ..... YES/NO
8. Have you experienced any problems related to a previous MR exam or procedure? ..... YES/NO

   If yes, then please describe……

WEIGHT:_____lbs HEIGHT:_____ Patient Signature:_____ Date:_____

CREAT:_____ DATE OF CREAT:_____ GFR:_____ CONTRAST: _____ ____ ML

SITE:_____ LOT:_____ TOTAL SCANS/IMAGES: _____

Technologist Signature: _____

COMMENTS:

The following items may be harmful to you during your MR scan or may interfere with the MR examination. You must provide a Yes or No for every item. Please indicate if you have or have had any of the following:

Yes	No	
___	___	Cardiac pacemaker or implanted cardiac defibrillator
___	___	Artificial heart valve or coronary artery bypass clips (When was the procedure_____)
		(***Assess the patient for surgical staples, clips, or metallic sutures***)
___	___	Cardiac stent (When and what type_____)
___	___	Aneurysm clip(s) in head or abdomen
___	___	Kidney Surgery
___	___	Intracranial clips
___	___	Shunt (spinal or intraventricular)
___	___	Any type of ear or cochlear implant
___	___	Artificial eye, orbital prosthesis, or any other implanted objects in eye(s)
___	___	Neurostimulator/Biostimulator/Bone stimulator
___	___	Implanted drug pump (e.g., insulin, Baclofen, chemotherapy, pain medicine)
___	___	Any implanted items (e.g., pins, rods, screws, nails, plates, wires) (where_____)
___	___	Artificial limb or joint (What and where_____)
___	___	Any type of **metallic** coil, filter, or stent (When and what type_____)
___	___	Any type of metal object inflicted into body especially the eyes (e.g., shrapnel, bullet, BB)
___	___	Tissue expander (e.g., breast)
___	___	Spinal fixation device or spinal fusion procedure (Where_____)
___	___	Penile implant
___	___	Diaphragm, IUD, Pessary (Type_____)
___	___	Any type of internal electrode(s) or wire(s)
___	___	Any I.V. access port (e.g., Broviac, Port-a-Cath, Hickman, Picc line)
___	___	Radiation seeds (e.g., cancer treatment)
___	___	Medication patch (e.g., Nitroglycerine, nicotine) if foil backing please remove. ***(Can affect dosage of meds)***
___	___	Tattoos or tattooed eyeliner
___	___	Removable dentures, false teeth or partial plate
___	___	Body piercing (***To be removed by the patient***) (Location_____)
___	___	Wig, hair implants, any hair accessories (e.g., bobby pins, barrettes, clips), or hearing aids
___	___	Jewelry

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 I have had the opportunity to ask questions regarding the information on this form.

Patient Signature: _____ Date: _____

Technologist Signature: _____