

MRI Patient History Questionnaire

Patient Name: _____

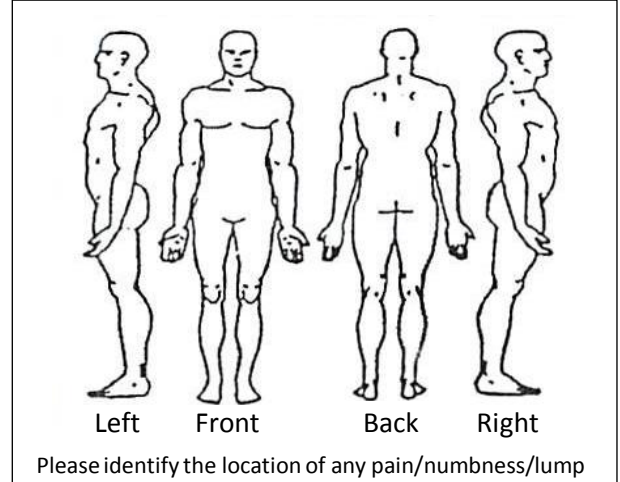
Account Number: _____

Reason for Procedure: _____

Date: _____

Are you experiencing any of the following symptoms? (Please check ALL that apply)

- | | |
|--|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Pelvic Pain | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Unexpected Weight Loss | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Shoulder Pain <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> Leg Pain <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Arm Pain <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Numbness <input type="checkbox"/> Right Side <input type="checkbox"/> Left Side | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Weakness <input type="checkbox"/> Right Side <input type="checkbox"/> Left Side | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Other _____ | |



How and when did these symptoms occur? _____

Medical History:

Do you have or have you had any of the following illnesses or conditions?

- | | | | |
|--|---|--|-----------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Arrhythmia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Kidney/Renal Failure | <input type="checkbox"/> Multiple Myeloma | <input type="checkbox"/> HIV/Aids |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumor, Lump or Mass | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Asthma, Bronchitis or Emphysema | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other _____ | |

Have you had any test (MRI, CT, X-Ray etc.) performed for the symptoms you are currently experiencing?

- No
- Yes If Yes, Please list the date, type of exam and facility where the test was performed.
- _____

Have you had any type of therapies (radiation therapy, chemotherapy etc.)?

- No
- Yes If Yes, Please list the date of therapy.
- _____

Do you have allergies (Medications, Food, Latex etc.)?

- No
- Yes If Yes, Please list all Allergies.
- _____

Have you ever had kidney disease/kidney transplant/pending kidney transplant?

- No
- Yes If Yes, please list history.
- _____

Have you ever had liver disease/liver transplant/pending liver transplant?

- No
- Yes If Yes, please list history.
- _____

Technologist's Notes: _____

MRI Patient Screening Questionnaire

Sex: **Male / Female (Please circle)**

Age: _____

Weight: _____

This questionnaire has been designed to assist us to determine if it is safe for you to undergo a Magnetic Resonance Imaging procedure(MRI). It is important that you answer all of the following questions. If you do not understand a question, please ask a staff member for assistance.

- | | | | | |
|---|------------------------------|-----------------------------|--|-------------------------------------|
| 1 Do you have a pacemaker, defibrillator, or implanted heart valves or wires? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> Don't Know |
| 2 Have you ever had any type of surgery? Please list all surgeries.
_____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> Don't Know |
| 3 Have you ever had any head surgery requiring aneurysm clips? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> Don't Know |
| 4 Do you have any type of electronic device (stimulator or pump) implanted in your body? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> Don't Know |
| 5 Do you have a hearing aid, middle/inner ear prosthesis or dentures? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> Don't Know |
| 6 Do you have any surgically implanted metal pins or joint prosthesis of any type in your body? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> Don't Know |
| 7 Have you ever been exposed to or worked around metal fragments that could be lodged in your eyes or body ? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> Don't Know |
| 8 Do you have tattoos, tattooed makeup, or body piercing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> Don't Know |
| 9 Do you wear a transdermal patch (nitroglycerin or nicotine)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> Don't Know |
| 10 Do you have a history of panic attacks or a fear of enclosed or narrow places? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> Don't Know |
| 11 Have you ever had a reaction to a contrast agent used for MRI, CT or X-ray? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> Don't Know |
| 12 Do you have any other items or device we should be aware of prior to performing the procedure? Please list all devices.
_____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> Don't Know |

FEMALES ONLY:

- | | | | | |
|--|------------------------------|-----------------------------|--|-------------------------------------|
| 13 Are you Pregnant or is it possible that you might be? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> Don't Know |
| 14 Are you breastfeeding? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | <input type="checkbox"/> Don't Know |

I certify that I have read and understand the questions asked in this questionnaire and that the above responses are correct to the best of my knowledge. I understand that it is my responsibility to inform San Gabriel Valley Diagnostic Center of any metal fragments or devices that may be in my body and that failure to do so may cause serious bodily injury or may be life threatening. I agree that should I have metal in my body and I elect to proceed with the MRI procedure, I agree to release San Gabriel Valley Diagnostic Center from any and all liability for injury.

Patient or Legal Representative Signature

Print Name

Date

Witness or interpreter Signature

Print Name

Date

Physician or Technologist Signature

Print Name

Date