MRI Screening Questionnaire

MORGAN HILL IMAGING

Patient Name: _____

Sex: _____ Age: _____ Weight: _____

This questionnaire is designed to assist us in determining if it is safe for you to undergo a magnetic resonance imaging procedure. It is important that you answer all of the following questions. **I you don't understand any question, please ask for assistance.**

1. Do you have a pacemaker, wires, defibrillator or implanted heart valves?	Yes ☐	No ☐	Don't Know ☐
2. Have you ever had any head surgery requiring aneurysm clips?	Yes ☐	No ☐	Don't Know ☐
3. Have you ever had any type of surgery?	Yes ☐	No ☐	Don't Know ☐
4. Have you ever had a reaction to a contrast agent used for MRI, CT, or X-ray?	Yes ☐	No ☐	Don't Know ☐
5. Do you have any surgically implanted metal of any type in your body?	Yes ☐	No ☐	Don't Know ☐
6. Have you ever been exposed to metal fragments that could be logged in your eyes or body?	Yes ☐	No ☐	Don't Know ☐
7. Do you have a hearing aid, middle/inner ear prosthesis, dentures or bridges?	Yes ☐	No ☐	Don't Know ☐
8. Do you have any metal pin, joint, prosthesis or metallic object in, or attached to your body?	Yes ☐	No ☐	Don't Know ☐
9. Do you have any type of electronic device (stimulator or pump) implanted in your body?	Yes ☐	No ☐	Don't Know ☐
10. Do you have or have you ever had tattoos, permanent eyeliner or lip liner, or body piercing?	Yes ☐	No ☐	Don't Know ☐
11. Are you wearing a transdermal drug patch? What kind?_____	Yes ☐	No ☐	Don't Know ☐
12. Do you have history of panic attacks or a fear of enclosed or narrow spaces?	Yes ☐	No ☐	Don't Know ☐
13. Do you have a history of drug or food allergies?	Yes ☐	No ☐	Don't Know ☐
14. Do you have history of renal (kidney) seizure, asthma or emphysema?	Yes ☐	No ☐	Don't Know ☐
15. Are you pregnant or is it possible that you may be pregnant?	Yes ☐	No ☐	Don't Know ☐
16. Are you breastfeeding?	Yes ☐	No ☐	Don't Know ☐

17. Is there any other item or device you believe we should know about prior to performing the MRI- if yes please describe:

_____

The greatest risk is a metallic object flying through the air toward the magnet and hitting you. To reduce this risk we require that all people involved with the study removed all metal from their clothing and all metal objects from their pockets. No metal objects are allowed to be brought into the magnet room at any time. In addition, once you are in the magnet, the door to the room will be closed so that no one inadvertently walks into the magnet.

I certify that I have read and understood 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 the center of any metal fragments and/or devices that may be in my body and that by failing to do so may cause serious bodily injury or be life threating. I agree that should I have any metal in my body and, after consultation with a physician, elect to proceed with the MRI, I agree to release Center from any and all liability for any injury.

Patient or Legal Representative Signature	Print Name and Authority (if legal representative)	Date
Witness or Interpreter Signature	Print Name	Date
Physician/Registered Nurse/Technologist	Printed Name	Date

Patient History Questionnaire (MRI)

MORGAN HILL IMAGING

Patient Name:_____ Date:_____

Reason for Procedure:

Please check any of the following symptoms that you are experiencing:

☐ Chest pain ☐ Headaches ☐ Nausea ☐ Hearing loss

☐ Abdominal pain ☐ Blackouts ☐ Blurred vison ☐ Ringing in ears

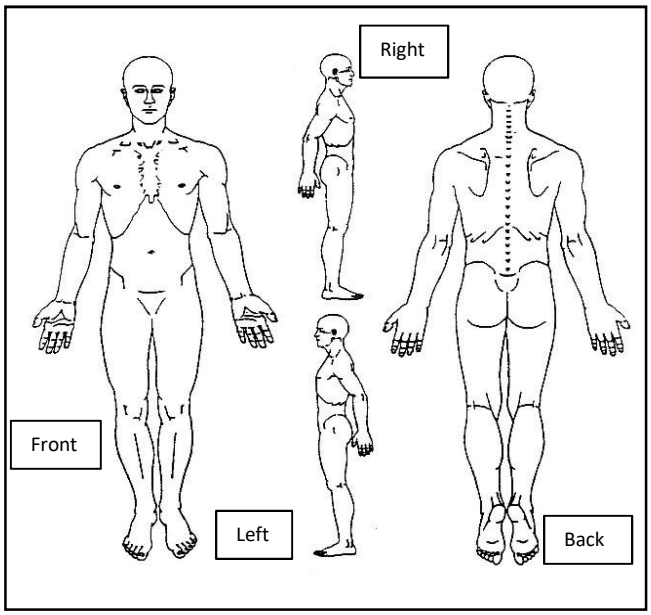
☐ Pelvic pain ☐ Dizziness ☐ Memory loss ☐ Seizures

☐ Back pain ☐ Neck pain ☐ Unexpected weight loss

☐ Shoulder pain-(☐ Right/☐Left) ☐ Numbness-(☐ Right side/☐ Left side)

☐ Leg pain-(☐ Right/☐Left) ☐ Weakness-(☐ Right side/☐ Left side)

☐ Arm-(☐ Right/☐Left) ☐ Other:_____



Please identify the location of any pain/numbness/limp

How and when did these symptoms occur (e.g., injury, just started, etc.)?

_____

_____

Medical History:

1. Do you have or have you had any of the following?

☐ Cancer ☐ Heart disease ☐ Kidney/renal disease ☐ Multiple myeloma ☐ Hypertension

☐ Seizures ☐ Sickle cell anemia ☐ Tumor, lump or mass ☐ Bleeding tendency ☐ Heart arrhythmia

☐ Diabetes ☐Congenital heart defect ☐ Glaucoma ☐ Stroke

☐ Asthma, bronchitis or emphysema ☐ Other illness/disease:_____

2. Have you had any tests (MRI, CT, X-Ray, etc.) performed for the symptoms you are currently experiencing? ☐ Yes ☐ No
If yes, please list the date and type of surgery or therapy:_____

_____

3. Have you had any surgeries or therapies (e.g., radiation therapy, chemotherapy, etc..)? ☐ Yes ☐ No
If yes, please list the date and type of surgery or therapy:_____

_____

4. Are you currently taking any medications? ☐ Yes ☐ No
If yes, please list all medications you are currently taking:_____

_____

5. Do you have any allergies (e.g., medications, latex, food, etc.)? ☐ Yes ☐ No
If yes, please list all allergies:_____

_____

I hereby certify that the above information is true and correct to the best of my knowledge.

_____ _____ _____

Patient or Legal Representative Signature | Print Name and Authority (life legal representative) | Date

Technologist Notes:_____

_____

_____