

MRI QUESTIONNAIRE-EXTREMITY

NAME: _____ D.O.B.: ____ / ____ / ____
(Last) (First)

AGE: _____ SEX: M / F WEIGHT: _____ HEIGHT: _____ ft. _____ in.

REFERRING PHYSICIAN: _____

- Which extremity will be scanned today? _____
- What type of problem are you having? _____
- Was this a result of an injury? _____
- How long have you had this problem? _____
- Do you have a history of being diagnosed with cancer? Yes ___ No ___ Type _____
- Have you been treated with either radiation or chemotherapy? (If yes, circle) Date Completed _____
- Have you had any surgery on the area being scanned? Yes ___ No ___
If Yes, when and what type? _____
- Have you ever had arthroscopy on the area being scanned? Yes ___ No ___
If yes, explain results _____
- Have you had an injection of the area being scanned? Yes ___ No ___ When _____
- Type of injection: _____

• **Do you have, or have you ever had, any of the following?: (If yes, circle)**

- | | | |
|--|--|-----------------------|
| PACEMAKER/DEFIBRILLATOR | METAL SLIVERS IN EYES | IUD |
| DIABETES or KIDNEY DISEASE | SHRAPNEL (bomb or bullet fragments) | HEARING AID |
| COCHLEAR IMPLANTS | BREAST TISSUE EXPANDER | BODY PIERCING |
| HEART VALVE REPLACEMENT | NEURO STIMULATOR | PENILE IMPLANT |
| TATOOS (over 20 years old) | PESSARY (bladder support) | ANEURYSM CLIPS |
| REMOVABLE DENTAL WORK/DENTURES | | |
| ENDOSCOPY CLIPS/INGESTED PILL CAMERA/PH BRAVO CAPSULE | | |
| MEDICATION PATCH (birth control/nicotine/Nitroglycerine) | | |
| ANY EXTERNAL/INTERNAL PUMPS (i.e., Insulin, chemotherapy) | | |

- Have you had any recent x-rays of this area? Yes ___ No ___ Where _____
- Have you ever had a bone scan? Yes ___ No ___
If yes, where and when? _____
- Do you have a history of allergies? Yes ___ No ___ If so, what kind? _____
- **Are you pregnant, or is there a possibility that you might be pregnant? Yes ___ No ___**

I acknowledge that all the information given is accurate and thereby consent to have Magnetic Resonance Imaging with or without an injection of contrast performed on me. I do not have a pacemaker. I have removed all hearing aids and dentures and any external pumps and monitoring devices.

Signature of Patient or Legal Guardian

Date: ____ / ____ / ____ Technologist's Initials: _____

Technologist to Complete the Section Below

MR # _____ Designated Physician On-Site: _____
Tech: _____ Supervising Physician (if different): _____
Contrast Used: OPTIMARK / _____ mls Lot # _____