

**MRI QUESTIONNAIRE-NECK**

NAME: \_\_\_\_\_ D.O.B: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Last) (First)

AGE: \_\_\_\_\_ SEX: M / F WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_ft. \_\_\_\_ in.

REFERRING PHYSICIAN: \_\_\_\_\_

- What type of problem are you having? \_\_\_\_\_
- How long have you had this problem? \_\_\_\_\_  
Is there a lump in your neck? Yes \_\_\_\_ No \_\_\_\_  
If yes, has it been biopsied? Yes \_\_\_\_ No \_\_\_\_

Do you have known or suspected problems with the blood circulation in the arteries of your neck? Yes \_\_\_\_ No \_\_\_\_

- Was this a result of an injury? \_\_\_\_\_ Date of injury \_\_\_\_\_
- 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 ever had surgery on your neck? Yes \_\_\_\_ No \_\_\_\_ Which side? Right \_\_\_\_ Left \_\_\_\_  
If yes, please describe what was done \_\_\_\_\_

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

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

- Have you ever had an ultrasound? Yes \_\_\_\_ No \_\_\_\_ When \_\_\_\_\_ Where \_\_\_\_\_
- Have you ever had any other x-rays or imaging tests of this area? (MRI/CT?) Yes \_\_\_\_ No \_\_\_\_  
What type? \_\_\_\_\_ When \_\_\_\_\_ Where \_\_\_\_\_
- 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 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**

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