Princeton Radiology
Excellence in Imaging

MRI QUESTIONNAIRE-
CERVICAL/THORACIC/LUMBAR SPINE

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

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

REFERRING PHYSICIAN: _____

- What type of problem are you having? _____
- Which side? Rt _____ Lt _____
- 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 previous surgery on your spine? Yes ___ No ___ When _____
  If yes, do you know at which levels? _____
- Have you had a spinal injection? Yes ___ No ___ When _____ Type _____
- Do you have pain, numbness, weakness or tingling? No ___ Yes ___ (circle which) Where _____

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

PACE MAKER	**METAL SLIVERS IN EYES**
ANEURYSM CLIPS	**SHRAPNEL (bomb or bullet fragments)**
COCHLEAR IMPLANTS	**HEARING AID**
HEART VALVE REPLACEMENT	**REMOVABLE DENTAL WORK/DENTURES**
NEURO STIMULATOR	**TATTOOS (over 20 yrs old)**
PESSARY (Bladder Support)	**IUD**
BODY PIERCING	**PENILE IMPLANT**

- Have you had a CAT scan of this area? Yes ____ No_____ Where_____ When _____
- Have you had a Myelogram of this area? Yes ____ No_____ Where _____ When _____
- Have you had a Bone Scan of this area? Yes ____ No_____ Where _____ When _____
- Have you had Plain X-rays of this area? Yes ____ No_____ Where _____ 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 performed on me.

I do not have a pacemaker. I have removed all hearing aids & dentures.

_____ **Date:** ____ / ____ / ____
Patient's Signature

Technologist to Complete Below this Line

Rad authorizing IV Contrast _____ Tech: _____ Study Protocoled by: _____

Contrast Used: _____ / _____ cc's Lot # _____ Study Checked by: _____

*This form was downloaded from www.princetonradiology.com.