Princeton Radiology
Excellence in Imaging

MRI QUESTIONNAIRE-**CHEST & ABDOMEN**

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

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

REFERRING PHYSICIAN: _____

- 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 ever had surgery on your chest or abdomen? Yes ____ No ____
  If yes what type? _____ Date: _____
- **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 ever had a CT scan, Ultrasound, or any other imaging studies done of the area being scanned? Yes__ No__
  If yes, what test/what area? _____
- Have you had any other diagnostics tests on the area that will be scanned today? Yes ____ No ____
  If yes, what type of test? _____
- Do you have a history of allergies? Yes ____ No ____ If yes, 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.