

MRI QUESTIONNAIRE-TMJ

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

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

REFERRING PHYSICIAN: _____

- What type of problem are you having? _____
- Was this a result of any 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 _____
- **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)		

- **Please circle only those that apply to you and circle the affected:**

Clicking	Lt	Rt	Headaches	Lt	Rt
Locking	Lt	Rt	Facial Pain	Lt	Rt
Crepitus	Lt	Rt	Limited Motion	Lt	Rt
(grating sound)			Pain in Teeth	Lt	Rt
Pain	Lt	Rt	Difficulty opening and closing your mouth?	Lt	Rt

- Have you had any previous treatment? Splint Therapy Arthroscopy TMJ Surgery
- Have you had any previous exams? Panorex Tomograms Arthrograms CT Scan MRI
- 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 # _____