MRI QUESTIONNAIRE (CHEST, ABDOMEN OR PELVIS)

NAME: _____ D.O.B:___/____/___ AGE: ____ SEX: M/ F
(Last) (First)

WT: ____ lbs HT:___ft.___in REFERRING PHYSICIAN:_____

- Please provide a summary of your symptoms specific to your exam today? _____

  _____
- Does your condition involve which side of your body (circle one?) RIGHT LEFT BOTH SIDES
- Are you experiencing any pain? YES NO If Yes, Circle one: Severe Moderate Mild
- Did symptoms/condition arise suddenly? YES NO
- How long have you been treated for this problem? _____
- What is/was the cause of the problem? Accident Motor Vehicle Fall Work-Related Injury (Complete injury form)
- Do you have (please circle, if applicable):

  Swelling Bruising Inflammation Contusion Sprain Open wound
- Did any existing disease/condition attributing to this current symptom/condition? _____
- Do you have a history of cancer? YES NO If yes, when was it diagnosed? _____ Type _____
- Have you been treated with either Radiation or Chemotherapy? (If yes, circle) Date Started _____ Completed _____
- Any surgery on area to be imaged? YES NO

  If Yes, when and what type? _____
- Any other medical (chest/renal disease/dialysis/liver disease) or a family history pertaining to your exam being performed today?

  _____
- Have you ever had an X-ray, CT Scan, MRI, Ultrasound or any other imaging studies done of the area being scanned? YES NO
  If yes, what test/what area? _____ Where: _____
- Have you ever had a reaction to MRI contrast? YES NO
  If yes, what type reaction? _____

FOR PATIENTS HAVING A PELVIC MRI:

- **Male patients:**
  - Have you had a biopsy of your prostate? Yes No When? _____ Where: _____ PSA Level = _____
- **Female patients:**
  - What was 1st day of menstrual cycle? _____
  - If postmenopausal, please give year of last period? _____
  - Are you pregnant or possibly pregnant? Yes No
  - Are you considering uterine embolization for fibroids? Yes No
  - Have you spoken with a physician regarding uterine artery embolization? Yes No
  - Have your ovaries been removed? Yes No If yes: when: _____

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, dentures, any external pumps and monitoring devices.

_____ **Date:___/____/____** **Technologist Initials:** _____
Patient's Signature

Tech notes: _____