MRI Extremity Questionnaire

Name: ____________________________  D.O.B. __/__/__  Sex: M/F  WT: _____ lbs

Why are you having the exam? (Symptom): ________________________________

What side, location, body part is involved? (Location): ________________________________

How long have you had this problem? (Duration): ________________________________

If due to injury, how did it occur? (Mechanism of Injury): ________________________________

☐ YES  NO  Have you ever had a reaction to MRI contrast?

☐ YES  NO  Is there any chance you may be pregnant? Date of last menstrual period? __________

☐ YES  NO  Do you wear a Dexcom, Libre, or other glucose monitor?

☐ YES  NO  Do you have Horizon Blue Cross/Blue Shield insurance? ________________________________

☐ YES  NO  Do you have a history of being diagnosed with cancer? Type? ________________________________

☐ YES  NO  Any radiation therapy? If YES, dates? ________________________________

☐ YES  NO  Any chemotherapy? If YES, dates/type? ________________________________

☐ YES  NO  Any prior imaging of the area? Where/when? ________________________________

☐ YES  NO  Any prior surgery of the area? Type/dates? ________________________________

☐ YES  NO  Have you ever had arthroscopy on the area being scanned?

☐ YES  NO  Have you had an injection of the area being scanned?

☐ YES  NO  Have you ever had any other imaging studies done of the area being scanned?

If yes, what test/what area? ________________________________

☐ YES  NO  Are you in a lung cancer screening program with yearly CTs of the chest?

☐ YES  NO  Do you now or have you ever smoked?

If YES, how many years did you smoke? ________ years

How many packs per day did you smoke? _____ packs per day

How long ago did you quit? If still smoking, mark as "0": _____ years ago

I acknowledge that all the information given is accurate and thereby consent to have MRI with or without an injection of contrast performed on me.

Signature: ________________________________  Date:__/__/____

Technologist Notes: ________________________________

__________________________

Technologist Initials: __________
MRI SCREENING FORM

NAME: __________________________  D.O.B: ___/___/___  AGE: ____  SEX: M / F

(Last)                 (First)

WT: ___lbs    HT: ___ft. ___in.    REFERRING PHYSICIAN: _______________________

Have you ever worked with metal or had an injury to your eyes involving metal?  Yes  No

Are you a welder, machinist or do you weld or grind metal?  Yes  No

Do you have any mechanical, shrapnel or other metallic foreign object implanted in your body?  Yes  No

Are you on dialysis?  Yes  No

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

PACEMAKER/WIRES/DEFIBRILLATOR  METAL SLIVERS IN EYES
IUD  DIABETES or KIDNEY DISEASE
SHRAPNEL (bomb or bullet fragments)  HEARING AIDS
COCHLEAR IMPLANTS  BREAST TISSUE EXPANDER
BODY PIERCING  HEART VALVE REPLACEMENT
NEURO/BONE/BLADDER STIMULATOR  PENILE IMPLANT
TATTOOS (over 20 years old)  TATTOOED EYELINER
PESSARY (bladder support)  ANEURYSM CLIPS
STENTS/SHUNTS  REMOVABLE DENTAL WORK/DENTURES
COLONOSCOPY/ENDOSCOPY CLIPS  INGESTED PILL CAMERA/PH BRAVO CAPSULE
BRACES  HISTORY OF EAR TUBES/IMPLANTS
ORTHOPEDIC HARDWARE  EYE LID SPRING/WIRE OR MAGNETIC EYELASHES
ANY EXTERNAL/INTERNAL PUMPS (i.e., Insulin, chemotherapy)  
MEDICATION PATCH (birth control/nicotine/Nitroglycerine)

I acknowledge that all the information given is accurate.
I do not have a pacemaker.
I have removed all hearing aids, dentures, any external pumps and monitoring devices.

____________________________  ____________________  __________
Patient’s Signature    Date:    Technologist Initials: ________