MRI QUESTIONNAIRE (EXTREMITY)

NAME: ____________________________  D.O.B: / /  AGE:  SEX: M/ F
   (Last)                           (First)
WT: ___ lbs     HT: ___ ft. ___ in     REFERRING PHYSICIAN: ____________________________

- Do you have Horizon Blue Cross/Blue Shield insurance?  YES  NO
- Please provide a summary of your symptoms specific to your exam today? ____________________________
- Does your condition involve a specific 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 contribute to this current symptom/condition? ____________________________
- Do you have a history of cancer?  YES  NO  When? __________ Type _______________
- Have you been treated with either Radiation or Chemotherapy?  (If yes, circle) Date Started ________ Completed ______
- Have you taken a drug called AVASTIN?  □ YES  □ NO  If Yes, when was the last time you received the drug AVASTIN? ______
- Any surgery on area to be imaged?  YES  NO  If Yes, when and what type? ____________________________
- Have you ever had arthroscopy on the area being scanned?  YES  NO  If Yes, explain results ____________________________
- Have you had an injection of the area being scanned?  YES  NO  Date: ________ Type: ______
- Any other medical or family history pertaining to your exam being performed today? ____________________________
- Have you ever had a X-ray, MRI, CT Scan, Ultrasound or any other imaging studies done of the area being scanned?  YES  NO  If yes, what test/what area? ____________________________ Where was the study performed? ____________________________
- Are you pregnant or possibly pregnant?  YES  NO
- Have you ever had a reaction to MRI contrast?  YES  NO  If yes, what type reaction? ____________________________

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: __________________________________________________________________________________________

updated 4/20/20