

MRI QUESTIONNAIRE - NECK

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? _____

- The symptoms primarily involve what part of your body? _____
If applicable, please circle: RIGHT or LEFT or BOTH sides of your body and/or UPPER or LOWER part of abdomen.
- Did this symptom/condition arise suddenly? Yes ___ No ___ When did the problem start? _____
- How long have you been treated for this problem? _____ Circle if problem is: Chronic or Acute or Temporary
- Is this your initial visit or follow-up visit? _____
- What is/was the cause of the problem? Accident Motor Vehicle Fall Work-Related Injury (Complete injury form)
- Are you having any pain? Yes ___ No ___ If Yes, circle if pain is severe or moderate or mild.
If Yes, circle if pain is generalized or localized. If localized pain, describe specific area of pain? _____
- Do you have any swelling or bruising or inflammation or contusion or sprain or open wound (please circle, if applicable)?
- Did any existing disease/condition attribute to this current symptom/condition? _____
- Do you have a history of being diagnosed with cancer? Yes ___ No ___ When? _____ Type _____
- Have you been treated with either Radiation or Chemotherapy? (If yes, circle) Date Started _____ Completed _____
- Any surgery on area to be imaged? Y ___ N ___ If Yes, when and what type? _____
- Is there a lump in your neck? Yes ___ No ___ If yes, has it been biopsied? Yes ___ No ___
- Do have a known or suspected problem with the blood circulation in the arteries of your neck? Yes ___ No ___
- Any other medical or family history pertaining to your exam being performed today? _____

• **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 | | STENTS |
| ENDOSCOPY CLIPS/INGESTED PILL CAMERA/PH BRAVO CAPSULE | | BRACES |
| MEDICATION PATCH (birth control/nicotine/Nitroglycerine) | | HISTORY OF EAR TUBES |
| ANY EXTERNAL/INTERNAL PUMPS (i.e., Insulin, chemotherapy) | | |

- 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? _____
- Are you pregnant or possibly pregnant? Yes ___ No ___ Have you ever had a reaction to MRI contrast? Yes ___ No ___
If yes, what type of 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.

Patient's Signature

Date: ___/___/___

Technologist Initials: _____