MRI QUESTIONNAIRE (NEURO)

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

WT: _____ lbs HT:_____ft._____in REFERRING PHYSICIAN/SPECIALTY:_____

- 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
- Are you experiencing (please circle, all that apply):

  Pain Numbness Weakness Tingling Where: _____
- Did any existing disease/condition contrubute to this current symptom/condition? _____
- Do you have a history of cancer? ☐YES ☐NO *If Yes*, When? _____ Type _____ Location _____
- Have you been treated with Radiation ☐YES ☐NO *If Yes*, Date Started _____ Completed _____ Body part _____
- Have you been treated with Chemotherapy? ☐YES ☐ NO *If Yes*, Dated Started _____ Completed _____
- Any surgery on area to be imaged including any biopsies? ☐YES ☐NO

  If Yes, when and what type? _____
- Have you had an injection of the area being scanned? ☐YES ☐NO *If yes*, Date: _____Type: _____
- Any other medical or family history pertaining to your exam being performed today? _____
- 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? _____
- Have you ever had a reaction to MRI contrast? ☐YES ☐ NO

  If yes, what type reaction? _____
- Female patients: Are you pregnant or possibly pregnant? ☐ YES ☐ NO

For TMJ imaging only:

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

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

_____

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