MRI QUESTIONNAIRE (NEURO)

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

(First) (Last)

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 contribute 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 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 Lt Rt
  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 Arthograms 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