

MRI QUESTIONNAIRE - TMJ

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? _____
- 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? (If yes, circle) Splint Therapy Arthroscopy TMJ Surgery
- Have you had any previous exams? (If yes, circle) Panorex Tomograms Arthrograms CT Scan MRI
- 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: _____