Princeton Radiology
Excellence in Imaging

MRI QUESTIONNAIRE (TMJ)

Name:_____ D.O.B.___/___/____ Sex: M/F WT:_____lbs

Why are you having the exam? (Symptom):_____

What side, location, body part are involved? (Location):_____

How long have you had this problem? (Duration):_____

If due to injury, how did it occur? (Mechanism of Injury):_____

☐ YES NO ☐ Have you ever had a reaction to MRI contrast?
☐ YES NO ☐ Is there any chance you may be pregnant? Date of last menstrual period?_____
☐ YES NO ☐ Do you wear a Dexcom, Libre, or other glucose monitor?
☐ YES NO ☐ Have you had a spinal injection? What type?_____
☐ YES NO ☐ Do you have a history of being diagnosed with cancer? Type?_____
☐ YES NO ☐ Any radiation therapy? If YES, dates?_____
☐ YES NO ☐ Any chemotherapy? If YES, dates/type?_____
☐ YES NO ☐ Any prior imaging of the area? Where/when? _____
☐ YES NO ☐ Any prior surgery of the area? Type/dates?_____

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	Pain in Teeth	Lt	Rt

Difficulty opening/closing your mouth? Lt Rt

Crepitus (grating sound) Lt Rt

Limited Motion 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

☐ YES NO ☐ Are you in a lung cancer screening program with yearly CTs of the chest?
☐ YES NO ☐ Do you now or have you ever smoked?
If YES, how many years did you smoke? _____.years
How many packs per day did you smoke? _____.packs per day
How long ago did you quit? If still smoking, mark as "0": _____.years ago

I acknowledge that all the information given is accurate and thereby consent to have MRI with or without an injection of contrast performed on me.

Signature:_____ Date:___/___/___

Technologist Notes:_____

_____

Technologist Initials:_____

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MRI SCREENING FORM

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

WT: ____lbs HT: ___ft. ___in. REFERRING PHYSICIAN: _____

Have you ever worked with metal or had an injury to your eyes involving metal?	Yes	No
Are you a welder, machinist or do you weld or grind metal?	Yes	No
Do you have any mechanical, shrapnel or other metallic foreign object implanted in your body?	Yes	No
Are you on dialysis?	Yes	No

Do you have, or have you ever had, any of the following: (If yes, circle)

PACEMAKER/WIRES/DEFIBRILLATOR
IUD
SHRAPNEL (bomb or bullet fragments)
COCHLEAR IMPLANTS
BODY PIERCING
NEURO/BONE/BLADDER STIMULATOR
TATTOOS (over 20 years old)
PESSARY (bladder support)
STENTS/SHUNTS
COLONOSCOPY/ENDOSCOPY CLIPS
BRACES
ORTHOPEDIC HARDWARE
METAL SLIVERS IN EYES
DIABETES or KIDNEY DISEASE
HEARING AIDS
BREAST TISSUE EXPANDER
HEART VALVE REPLACEMENT
PENILE IMPLANT
TATTOOED EYELINER
ANEURYSM CLIPS
REMOVABLE DENTAL WORK/DENTURES
INGESTED PILL CAMERA/PH BRAVO CAPSULE
HISTORY OF EAR TUBES/IMPLANTS
EYE LID SPRING/WIRE OR MAGNETIC EYELASHES
ANY EXTERNAL/INTERNAL PUMPS (i.e., Insulin, chemotherapy)
MEDICATION PATCH (birth control/nicotine/Nitroglycerine)

I acknowledge that all the information given is accurate.
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