

# UNIVERSITY DIAGNOSTIC MEDICAL IMAGING P.C.

## MRI QUESTIONNAIRE

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

NAME: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

CURRENT WEIGHT: \_\_\_\_ LBS

CURRENT HEIGHT: \_\_\_\_ FEET \_\_\_\_ INCHES

**PLEASE NOTE: CARDIAC PACEMAKERS ARE PROHIBITED  
AS THEY MAY RESULT IN SERIOUS HARM OR DEATH!**

*The following questions must be answered to determine if you qualify to have a MRI*

**Please describe the problem or reason which necessitated this examination.**

**Have you ever had a surgical procedure or operation of any kind? .....** Y / N

If yes, please list all prior surgeries/dates: \_\_\_\_\_

- **Cardiac/heart surgery involving:** artificial heart valves, stents, cardiac defibrillator (ICD), or pacemaker? ..... Y / N
- **Brain/head, eye or ear surgery in which metallic implants may have been placed** (e.g. aneurysm clips, cochlear (ear) implants, shunt, metal plates or surgical staples)? ..... Y / N

**Have you ever been injured by any metallic foreign body?** (e.g. bullet, BB, shrapnel, etc.)..... Y / N

If yes, please describe: \_\_\_\_\_

**Have you ever had an injury to the eye involving a metallic object** (e.g. metallic slivers, shavings, foreign body, etc.) Or have you worked as a sheet metal worker? ..... Y / N

If yes, please describe: \_\_\_\_\_

**Do you have an artificial or prosthetic limb or a joint replacement** (hip, knee, etc.)? ..... Y / N

If yes, please describe: \_\_\_\_\_

**Do you have a history of renal disease, seizure, asthma, contrast reactions, or allergies to medication?** ..... Y / N

If yes, please describe: \_\_\_\_\_

**Do you have a breast tissue expander implant?** ..... Y / N

If yes, please describe: \_\_\_\_\_

**Do you have any type of electronic, mechanical or metal implant or hearing aid?**..... Y / N

If yes, please describe: \_\_\_\_\_

**Do you have any history of cancer or tumor?** ..... Y / N

If yes, please describe: \_\_\_\_\_

**Are you pregnant or do you suspect that you are pregnant?**..... Y / N

**Do you have tattooed eyeliner?** ..... Y / N

*If yes, please inform the technologist prior to the examination.*

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient's signature \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

TECH NOTES/ DX (Reserved for MRI technologist use)

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## ACCIDENT RELATED DISCLAIMER

PATIENT NAME: \_\_\_\_\_

I hereby certify that the reason for the test(s) being ordered today by my referring physician, Dr. \_\_\_\_\_, is (are) not due to either a job-related injury or an automobile accident.

Since there was no accident involved, and therefore no other insurance responsible, I give my permission for University Diagnostic Medical Imaging, PC, to bill my private insurance company, \_\_\_\_\_, for these studies.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_