



**MRI PATIENT QUESTIONNAIRE**

Patient MRN# \_\_\_\_\_ Exam Performed: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Sex: M / F    Weight: \_\_\_\_\_    Height: \_\_\_\_\_    Age: \_\_\_\_\_    Date of Birth: \_\_\_\_\_

Allergies: \_\_\_\_\_

List all previous surgeries: \_\_\_\_\_

Do you have a return appointment scheduled with your doctor? \_\_\_\_\_

If yes, when and where? \_\_\_\_\_

Did you take any claustrophobia medication for your test today? \_\_\_\_\_

**Do you have:**

- | YES   | NO    |                           |
|-------|-------|---------------------------|
| _____ | _____ | Stents                    |
| _____ | _____ | Aneurysm Clips            |
| _____ | _____ | Ear Implants              |
| _____ | _____ | Joint Replacements        |
| _____ | _____ | Cardiac Valve Replacement |
| _____ | _____ | Artificial Limbs          |
| _____ | _____ | Dentures or Partials      |
| _____ | _____ | Hearing Aids              |
| _____ | _____ | Neurostimulator           |
| _____ | _____ | Cardiac Pacemaker         |
| _____ | _____ | Shrapnel / Bullets        |
| _____ | _____ | Diabetes                  |
| _____ | _____ | Kidney Disease            |
| _____ | _____ | Sickle Cell Anemia        |
| _____ | _____ | Implanted Pain Pump       |
| _____ | _____ | Insulin Pump              |
| _____ | _____ | Any other Removable Pumps |

- | YES   | NO    |  |
|-------|-------|--|
| _____ | _____ | Brain Surgery                                    |
| _____ | _____ | Blood Vessel Surgery                             |
| _____ | _____ | Neck Surgery                                     |
| _____ | _____ | Ear Surgery                                      |
| _____ | _____ | History of Metal Shavings in<br>the Face or Eyes |
| _____ | _____ | History of Cancer                                |
| _____ | _____ | Eyeliner Tattoos                                 |

**Are You:**

- |       |       |                   |
|-------|-------|-------------------|
| _____ | _____ | Pregnant          |
| _____ | _____ | Possibly Pregnant |

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Imaging Center Witness

\_\_\_\_\_  
Relative or Legal Guardian  
(If patient is unable to sign or is a minor)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

**Patient History:**

\_\_\_\_\_ This patient has been educated as to the nature, extent, and risks associated with this examination. \_\_\_\_\_