

MRI/RADIOLOGY QUESTIONNAIRE

NAME: _____ D.O.B. _____

WHERE IS THE BEST PLACE TO REACH YOU DURING THE DAY?

HOME _____ CELL _____ WORK _____

MAY WE LEAVE A MESSAGE ON VOICE MAIL? Yes No

MAY WE LEAVE INFORMATION WITH ANOTHER INDIVIDUAL?

WHO? _____

MRI ONLY –

THESE QUESTIONS WILL HELP US TO SCHEDULE YOUR PROCEDURE:

Are you claustrophobic? Yes No

Are you allergic to gadodiamide contrast? Yes No

Do you have any METAL in your body such as plates, screws or other metal? Yes No

(exclude routine dental work and braces)

If yes, where and what year? _____

Do you have any medical devices such as a pacemaker, heart valve, or stents? Yes No

If yes, what kind? _____

Are you diabetic? Yes No

If yes, are you taking GLUCOPHAGE? Yes No

Do you have any RENAL/KIDNEY or LIVER DISEASE? Yes No

Do you have an aneurysm clip in your brain or abdomen? Yes No

Do you have a neurostimulation device (i.e., spinal cord, bladder) Yes No

Do you have an insulin, baclofen, or other infusion pump placed in your body? Yes No

Have you ever worked around or with metal? (welding, grinding, etc.) Yes No

Have you ever had any metal removed from your eyes? Yes No

Do you have ear implants (cochlear, otologic) Yes No

Have you ever had any surgery to the area being scanned? Yes No

Have you ever had any cataract surgery? Yes No

Do you have any PERSONAL history of cancer? Yes No

If yes, where and what year? _____

Have you had a **previous MRI**? Yes No

If **yes**: on what part of the body, _____, what facility, _____

and month/year of exam? _____ *Any History of Renal Disease? Y N

WEIGHT: _____ HEIGHT: _____ *Are you Diabetic? Y N

SCHEDULING: Please circle the days that are best for you.

MON. TUES. WED. THURS. FRI. SAT.

Do you prefer: MORNING, AFTERNOON, EVENING, ANYTIME?

FEMALES ONLY – ARE YOU PREGNANT? Yes No **DO YOU HAVE AN IUD?** Yes No