MEMORIAL RADIOLOGY ASSOCIATES, LLC
MRI QUESTIONNAIRE FORM

Patient Name: _____

Type of exam: _____ Weight: _____

Please indicate if you have any of the following: (Circle all Yes or No)*

Pacemaker or defibrillator	Yes	No	Breast Tissue expanders	Yes	No
Brain aneurysm clip or coil	Yes	No	Port-a-Cath	Yes	No
Cardiac Stent	Yes	No	Tattoos or Piercing	Yes	No
Artificial Heart Valve	Yes	No	Implanted catheter or tube	Yes	No
Ear implant	Yes	No	Anything in body not born with	Yes	No
Eye implant	Yes	No	Neuro, Bone or Bio-stimulator	Yes	No
Bullets or BB's	Yes	No	Renal Transplant Clips	Yes	No
Infusion pump	Yes	No	Shunt	Yes	No
Magnetic implant anywhere	Yes	No	Diaphragm, IUD or Pessary	Yes	No
Orthopedic hardware	Yes	No	Transdermal Patch (i.e. nicotine or nitro)	Yes	No
Artificial limb or joint	Yes	No	Other _____	Yes	No
Location: _____			How long go ago implanted/inserted? _____		

Are you allergic to any medication? Yes No
If yes, list medication and reaction: _____

Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? Yes No

Have you had a previous CT/MRI scan performed? Yes No
If yes, when and where was it performed? What body part? _____

History of cancer? Yes No
If yes, what type and how is it being treated? _____

Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, liver (hepatic) disease, or a history of diabetes? Yes No
If yes, please describe: _____

Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? Yes No

Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, foreign body, etc.)? Yes No

Are you claustrophobic? Yes No **Ever suffer from or had Epilepsy/Seizure?** Yes No

Reason for MRI and/or Symptoms: _____

Prior Surgeries: _____

For Female Patients Only: I could be pregnant. Yes No My last menstrual period began on: _____

I attest that the above information is correct to the best of my knowledge. I read & understand the contents of this form & had the opportunity to ask questions regarding the information on this form & regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date ____/____/____

****Only if ordered with contrast.** I consent to the use of IV MRI contrast: Signature _____**

Advanced Directive/ Living will? Yes No (If yes, please provide a copy to the technologist so we can respect your wishes)
If No, would you like information on Advanced Directives/ Living Wills? Yes No