

Mt. Scott Diagnostic Imaging
MRI Questionnaire

Name _____ DOB _____ Today's Date _____

Ht ___ ft ___ in. Weight _____ Body part to be scanned _____ Date of injury _____

How were you injured? _____

Symptoms _____ How long? _____

Type of treatment _____

Have you had prior testing on the area being scanned today? YES/ NO

MRI CT US X-RAY Date _____ Facility _____

Have you had surgery in the same area? YES/ NO

Date _____ Facility _____ Reason _____

History of cancer? YES/ NO

Date _____ Facility _____ Treatment _____

Have you had brain surgery? YES/ NO

Date _____ Facility _____ Reason _____

Are you or could you be pregnant? YES/NO

How many weeks? _____

Any prior surgeries where metal parts were left in your body? YES/NO Where? _____

Do you have a pacemaker? YES/NO

Do you have any implanted electronic devices? YES/NO What? _____

Are you at risk for having metal fragments in your eyes due to job or hobbies? YES/NO

Are you claustrophobic? YES/NO

Do you use nitroglycerine patches? YES/NO

Do you wear hearing aids, pagers, or any other electronic devices? YES/NO What? _____

When is your follow apt? _____

PLEASE DO NOT WRITE BELOW

Tech note: _____

IV Contrast _____ CC of _____

Sedation _____