Angel Williamson
a place for hope, health and happiness
IMAGING CENTER
PET/CT • CT • MRI • DEDICATED BREAST MRI • DIGITAL MAMMOGRAPHY • BONE DENSITY • ULTRASOUND

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MRI QUESTIONNAIRE

Patient Name: ______________________________ DOB: __________________

Referring Physician: ________________________

Other physician(s) to receive report: ____

Patient fax: ____________________ Patient e-mail address: ______________________________

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind?__No __Yes
   Please indicate date and type of surgery:
   Date:___/___/___ Type of surgery:__________________________________
   Date:___/___/___ Type of surgery:__________________________________
   Date:___/___/___ Type of surgery:__________________________________

2. Have you had prior diagnostic imaging study (MRI, CT, X-ray, Ultrasound, etc)? __No __Yes

Please List:	**Body Part**	**Date**	**Facility**
MRI	______________________	___/___/___	___________________
CT	______________________	___/___/___	___________________
X-ray	______________________	___/___/___	___________________
Ultrasound	______________________	___/___/___	___________________
Nuc Med	______________________	___/___/___	___________________
Other	______________________	___/___/___	___________________

3. Have you experienced any problem related to a previous MRI exam or MR procedure? __No __Yes
   If yes, please describe: ____
4. Have you had injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ___No ___Yes
   If yes, please describe:____
5. Have you been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.) __No __Yes
   If yes, please describe:____
6. Are you currently taking or have you recently taken any medications or drugs? __No __Yes
   If yes, please list:____
7. Are you allergic to any medications? __No __Yes
   If yes, please list:____
8. 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? __No __Yes
9. Do you have anemia or any disease(s) that affects your blood, history of renal (kidney) disease, renal failure, renal transplant, high blood pressure (hypertension), liver (hepatic) disease or seizures? __No __Yes If yes, please describe:____

FEMALE PATIENTS

10. Date of last menstrual period:___/___/___ Post menopausal? __No __Yes
11. Are you pregnant or experiencing a late menstrual period? __No __Yes
12. Are you taking any type of fertility medication or having fertility treatments? __No __Yes
    If yes, please describe:____
14. Are you currently breastfeeding? __No __Yes