MRI Questionnaire

Name:_____ Date:_____

Height:_____ Weight:_____ Age:_____ Are you claustrophobic? ☐ Yes ☐ No

Is test due to symptoms from: (circle one) Motor Vehicle Accident On Job Injury Personal Injury Illness Unknown

What are your main symptoms or type of injury?_____

How long have you had symptoms?_____ Date of injury:_____

Have you had surgery in the area we are scanning? ☐ Yes ☐ No If yes, what type of surgery?_____

Location of surgery (Hospital):_____ Date of surgery:_____

Have you had X-rays of the area we are scanning? ☐ Yes ☐ No If yes, name of facility/date:_____

Have you had a CT of the area we are scanning? ☐ Yes ☐ No If yes, name of facility/date:_____

Have you had an MRI of the area we are scanning? ☐ Yes ☐ No If yes, name of facility/date:_____

Have you had an Ultrasound of the area we are scanning? ☐ Yes ☐ No If yes, name of facility/date:_____

Have you had a Nuclear Medicine scan of the area? ☐ Yes ☐ No If yes, name of facility/date:_____

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If yes, what kind?_____

Have you had radiation therapy? ☐ Yes ☐ No If yes, what kind and what body part?_____

Are you pregnant, or is it possible that you are pregnant? ☐ Yes ☐ No Are you diabetic? ☐ Yes ☐ No

Check ONLY symptoms related to the type of MRI Scan you are having today

BRAIN

☐ Headaches If yes, location _____
☐ Seizures ☐ Weakness
☐ Dizziness ☐ Vertigo
☐ Trouble Walking
☐ MS or Suspicion of MS If yes, year diagnosed:_____
☐ Speech Issues / Trouble Talking
☐ Blurred Vision ☐ Double Vision
☐ Memory Loss
☐ Loss of Vision ☐ Right ☐ Left
☐ Hearing Loss ☐ Right ☐ Left
☐ Ringing or Roaring in Ears ☐ Right ☐ Left
☐ Stroke If yes, date:_____
☐ Brain Surgery If yes, type of surgery:_____
☐ Paralysis ☐ Right ☐ Left

SPINE (Cervical / Thoracic / Lumbar)

☐ Back Pain ☐ Neck Pain
☐ Upper ☐ Middle ☐ Lower
☐ Dull ☐ Sharp ☐ Both
Weakness in: ☐ Arm ☐ Leg ☐ Right ☐ Left
Pain in: ☐ Arm ☐ Leg ☐ Right ☐ Left
If yes, which area of arm / leg?_____
Numbness in: ☐ Arm ☐ Leg ☐ Right ☐ Left

NECK (Soft Tissue)

☐ Lump or Mass If yes, location of mass:_____
☐ Difficulty Swallowing
☐ Difficulty Talking
☐ Pain If yes, location:_____
☐ Sore Throat

Shoulder / Arm / Elbow / Hand / Wrist / Finger / Hip / Leg / Knee / Ankle / Foot

Body Part:_____ ☐ Right ☐ Left
☐ Pain if yes, describe: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning
Location of pain:_____
☐ Swelling
If yes, location of:_____
☐ Lump or Mass
If yes, location of mass:_____
☐ Numbness ☐ Weakness ☐ Stiffness
☐ Popping ☐ Grinding
☐ History of Dislocation
☐ Limited Range of Motion

PLEASE TURN OVER

Check ONLY symptoms related to the MRI scan you are having today

Abdomen

☐ Abdominal Pain If yes, describe below:

☐ Sharp ☐ Dull ☐ Aching ☐ Burning

Location of Pain: _____

☐ Loss of Appetite

☐ Nausea / Vomiting

☐ Bowel Changes

☐ Bladder Changes

☐ Weight Loss or Gain

☐ Gallbladder Removed

☐ Appendectomy

☐ Abnormal Lab Work

Female Pelvis

☐ Pelvic Pain If yes, location: _____

☐ Mass / Cyst / Polyp

☐ Pelvic Surgery If yes, type of surgery: _____

☐ Irregular Menstruation

☐ Painful Menstrual Cycles

☐ Painful Intercourse

☐ Hysterectomy

☐ Ovaries Removed

Male Pelvis

☐ Pain If yes, location: _____

☐ Lump or Mass

☐ Trauma

☐ Blood in Urine

☐ Prostate Cancer

☐ Pelvic Surgery If yes, type of surgery: _____

☐ Steroid or Radiation Therapy

☐ Implant If yes, type of implant: _____

Chest

☐ Difficulty Breathing

☐ Pain If yes, location of pain: _____

☐ Mass If yes, location of mass: _____

☐ Heart Disease

☐ Moist Cough

☐ Dry Cough

☐ Rib Pain

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

Patient / Guardian Signature: _____ **Today's Date:** _____

FOR STAFF USE:

Screening Performed by: ☐ MR Technologist ☐ Nurse ☐ Radiologist ☐ Other: _____

Staff Signature: _____ Print Name: _____