THE IMAGING CENTER - COOKEVILLE REGIONAL MEDICAL CENTER - MRI QUESTIONNAIRE PART 1

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each of the following. Do you have any of the following:

❑Yes	❑No	Cardiac Pacemaker
❑Yes	❑No	Implanted cardiac defibrillator
❑Yes	❑No	Aneurysm clip(s)
❑Yes	❑No	Carotid artery vascular clamp
❑Yes	❑No	Internal pacing wires Initial_____
❑Yes	❑No	Intravascular stents, filters, or coils
❑Yes	❑No	Shunt (spinal or intraventricular)
❑Yes	❑No	Insulin or infusion pump
❑Yes	❑No	Implanted drug infusion device
❑Yes	❑No	Bone growth/fusion stimulator
❑Yes	❑No	Cochlea, otologic, or ear implant
❑Yes	❑No	Any type of prosthesis (eye, penile, etc.)
❑Yes	❑No	Heart valve prosthesis
❑Yes	❑No	Artificial limb or joint
❑Yes	❑No	Electrodes (on body, head, or brain)
❑Yes	❑No	Vascular access port and/or catheter
❑Yes	❑No	Swan-Ganz catheter
❑Yes	❑No	Any implant held in place by a magnet
❑Yes	❑No	Transdermal delivery system (Nitro)
❑Yes	❑No	IUD or Diaphragm
❑Yes	❑No	Tattooed makeup (eyeliner, lips, etc.)
❑Yes	❑No	Body piercing(s)
❑Yes	❑No	Any metal fragments
❑Yes	❑No	Aortic clip
❑Yes	❑No	Metal or wire mesh implants
❑Yes	❑No	Wire sutures or surgical staples
❑Yes	❑No	Harrington rods (spine)
❑Yes	❑No	Metal rods in bones
❑Yes	❑No	Joint replacement_____
❑Yes	❑No	Bone/joint pin, screw, nail, wire, plate
❑Yes	❑No	Hearing aid (Remove before MRI)
❑Yes	❑No	Dentures (Remove before MRI)
❑Yes	❑No	Metal Shavings in Eyes
❑Yes	❑No	Allergies to medications

List: _____

_____

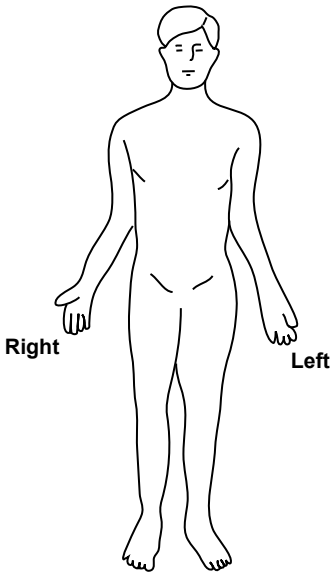
Weight: _____ Height: _____

Is there a chance you maybe pregnant? ❑Yes ❑No

Are you currently taking birth control? ❑Yes ❑No

When was your last menstrual cycle? _____

Please mark on the figure below, the location of any implant or metal inside of or on your body.



What problems are you having? _____

_____

_____

Is this due to an injury? _____

Explanation: _____

How long has this been going on? _____

Have you ever been diagnosed with cancer? _____

Did you receive: ❑ Chemotherapy ❑ Radiation

Reviewed by PCA_____Office Staff_____

Before your MRI, please remove all metallic objects including keys, hair pins, barrettes, jewelry, watch, safety pins, paper-clips, money clip, credit cards, coins, pens, belt, metal buttons, pocket knife, & clothing with metal in the material.

NOTE: YOU ARE REQUIRED TO WEAR EARPLUGS OR EARPHONES DURING THE MRI EXAMINATION.

PATIENT NAME (PRINT): _____ DATE: _____

_____ _____

SIGNATURE OF PATIENT/GUARDIAN REVIEWED BY MRI TECH

PATIENT ID STICKER

To be completed by the MRI Facility:

Medical record number:_____ Completed by: _____

Procedure:_____

Contrast: _____ Amount: _____

Diagnosis: _____

Clinical History: _____

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❑Yes ❑No Cardiac Pacemaker
❑Yes ❑No Implanted cardiac defibrillator
❑Yes ❑No Aneurysm clip(s)
❑Yes ❑No Carotid artery vascular clamp
❑Yes ❑No Internal pacing wires Initial_____
❑Yes ❑No Intravascular stents, filters, or coils
❑Yes ❑No Shunt (spinal or intraventricular)