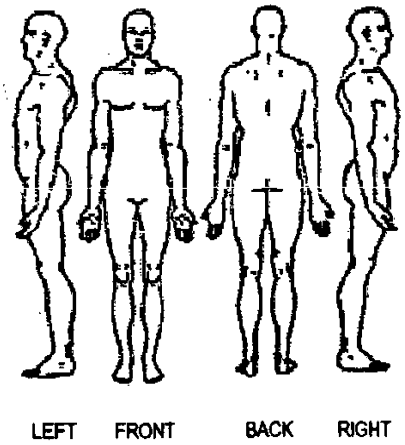
Mon Health™ Medical Center

X-160

Patient History Questionnaire (MRI)

Patient Name: _____ Date: _____



Please identify the location of any pain/numbness/lump

Reason for Procedure:

Please check any of the following symptoms that you are experiencing:

☐ Chest pain	☐ Headaches	☐ Nausea	☐ Hearing loss
☐ Abdominal pain	☐ Blackouts	☐ Blurred vision	☐ Ringing in ears
☐ Pelvic pain	☐ Dizziness	☐ Memory Loss	☐ Seizures
☐ Back pain	☐ Neck pain	☐ Unexpected weight loss	
☐ Shoulder pain-(☐Right/☐Left)		☐ Numbness-(☐Right side/☐Left side)	
☐ Leg pain- (☐Right/☐Left)		☐ Weakness- (☐Right side/☐Left side)	
☐ Arm pain-(☐Right/☐Left)		☐ Other: _____	

How and when did these symptoms occur (e.g., injury, just started, etc.)?

_____

_____

Medical History:

1. Do you have or have you had any of the following?

☐ Cancer	☐ Heart disease	☐ Kidney/renal disease	☐ Multiple myeloma	☐ Hypertension
☐ Seizures	☐ Sickle cell anemia	☐ Tumor, lump or mass	☐ Bleeding tendency	☐ Heart arrhythmia
☐ Diabetes	☐ Congenital heart defect	☐ Glaucoma	☐ Stroke	
☐ Asthma, bronchitis or emphysema		☐ Other illness/disease: _____		

2. Have you had any tests (MRI, CT, X-Ray, etc.) performed for the symptoms you are currently experiencing?
☐ Yes ☐ No If Yes, please list the date, type and who performed the test: _____

3. Have you had ANY surgeries? (This question is not limited to the body part being examined today.) ☐ Yes ☐ No
If yes, please list the date and type of surgery: _____

4. Have you had any therapies (e.g. radiation therapy, chemotherapy, etc.)? ☐ Yes ☐ No
If yes, list date and type of therapies: _____

5. Do you have any allergies (e.g., medications, latex, food, etc.)? ☐ Yes ☐ No
If yes, please list all allergies: _____

6. Have you had an IV drug in the last 3 months for iron deficiency anemia (drug called Feraheme)? ☐ Yes ☐ No

I hereby certify that the above information is true and correct to the best of my knowledge.

Time	Date	Patient or Legal Representative Signature	Print Name and Authority (if legal representative)

Technologist Notes: _____

QUESTIONNAIRE CONTINUES ON THE BACK

PLACE PATIENT LABEL HERE

MRI Screening Questionnaire

Patient Name: _____ Medical Record #:_____ Date of Birth: _____

Date of MRI: _____ Sex: Male/Female Age: ___ Ht:_____ Wt:_____

This questionnaire is designed to assist us in determining if it is safe for you to undergo a Magnetic Resonance Imaging procedure. It is important that you answer all of the following questions.

If you don't understand any question, please ask for assistance.

1. Do you have a pacemaker, or loop recorder, defibrillator?	Yes ☐ No ☐ I don't know ☐
2. Do you have wires or heart valves?	Yes ☐ No ☐ I don't know ☐
3. Do you have any stents (heart stents, renal stents, etc.)?	Yes ☐ No ☐ I don't know ☐
4. Have you ever had any head surgery requiring aneurysm clips?	Yes ☐ No ☐ I don't know ☐
5. Have you ever had any type of surgery?	Yes ☐ No ☐ I don't know ☐
6. Have you ever had a reaction to a contrast agent used for MRI, CT or X-ray?	Yes ☐ No ☐ I don't know ☐
7. Do you have any surgically implanted metal of any type in your body?	Yes ☐ No ☐ I don't know ☐
8. Do you have any type of electronic device (stimulator, shunt, or pump) implanted in your body?	Yes ☐ No ☐ I don't know ☐
9. Have you ever been exposed to metal fragments that could be lodged in your eyes or body?	Yes ☐ No ☐ I don't know ☐
10. Do you have a hearing aid, middle/inner ear prosthesis or dentures?	Yes ☐ No ☐ I don't know ☐
11. Do you have any metal pin, joint, prosthesis or metallic object in, or attached to, your body?	Yes ☐ No ☐ I don't know ☐
12. Do you have or have you ever had tattoos, tattooed eyeliner, lip liner or body piercing?	Yes ☐ No ☐ I don't know ☐
13. Do you wear a transdermal patch (nitroglycerin or nicotine)?	Yes ☐ No ☐ I don't know ☐
14. Do you have a history of panic attacks or a fear of enclosed or narrow places?	Yes ☐ No ☐ I don't know ☐
15. If you are a woman, are you pregnant, or is it possible that you might be pregnant?	Yes ☐ No ☐ I don't know ☐
16. If you are a woman, are you breastfeeding?	Yes ☐ No ☐ I don't know ☐
17. Is there any other item or device you believe we should know about prior to performing the procedure-if yes, please describe:	Yes ☐ No ☐ I don't know ☐
18. Have you had a colonoscopy (colon scope) or endoscopy (stomach scope) performed in the past year? If **YES**, was the scope done for GI bleeding, removing large polyps, or closure of mucosal defects, or perforations?	Yes ☐ No ☐ I don't know ☐ Yes ☐ No ☐ I don't know ☐
19. Do you wear colored contacts?	Yes ☐ No ☐ I don't know ☐

This patient safely meets all scanning criteria. Tech initials:_____

PLACE PATIENT LABEL HERE