

XRAY # _____

MR# _____

**ANGEL MEDICAL CENTER
DEPARTMENT OF RADIOLOGY
MRI QUESTIONNAIRE**

NAME _____ BIRTHDATE _____ WEIGHT _____

HAVE YOU HAD ANY SURGERY IN THE PAST SIX WEEKS? _____ IF YES, WHEN? _____

WHAT KIND? _____

ARE YOU, OR COULD YOU BE PREGNANT? _____ IF YES, HOW MANY WEEKS? _____

HAVE YOU TAKEN ANY TYPE OF SEDATION? _____

THE FOLLOWING ITEMS MAY BE HAZARDOUS WITH MRI SCANNING. PLEASE CHECK THE APPROPRIATE COLUMN FOR EACH OF THE FOLLOWING:

- | YES | NO | |
|-----|-----|---|
| ___ | ___ | CARDIAC PACEMAKER OR DEFIBULATOR |
| ___ | ___ | INTRACRANIAL ANEURYSM CLIPS (BRAIN) |
| ___ | ___ | WORKED IN METAL SHOP |
| ___ | ___ | KNOWN METAL FRAGMENTS IN OR AROUND EYES |
| ___ | ___ | EAR IMPLANT |
| ___ | ___ | INSULIN PUMP |
| ___ | ___ | ELECTRODES |
| ___ | ___ | NEUROSTIMULATOR (TENS UNIT) |
| ___ | ___ | HEARING AID |
| ___ | ___ | HEART VALVE OR STENT |
| ___ | ___ | EYE IMPLANT |
| ___ | ___ | SWALLOWED A GI CAMERA WITHIN LAST 10 DAYS |

THE FOLLOWING ITEMS MAY INTERFERE WITH MRI SCANNING. PLEASE CHECK THE APPROPRIATE COLUMN FOR EACH OF THE FOLLOWING:

- | YES | NO | |
|-----|-----|--|
| ___ | ___ | METAL IMPLANTS (IF YES, PLEASE EXPLAIN) |
| ___ | ___ | VENOUS "UMBRELLA" |
| ___ | ___ | SHUNT, SPINAL OR VENTRICULAR |
| ___ | ___ | JOINT REPLACEMENT |
| ___ | ___ | HARRINGTON ROD |
| ___ | ___ | BONE OR JOINT PINS, SCREWS, WIRE SUTURES |
| ___ | ___ | AORTIC CLIPS |
| ___ | ___ | SHRAPNEL/BULLET/BB |
| ___ | ___ | IUD |
| ___ | ___ | PROSTHESIS |
| ___ | ___ | SKIN PATCH MEDICINES |
| ___ | ___ | PARTIAL PLATES OR DENTAL MAGNETS |

ANY OTHER IMPLANTS NOT LISTED? _____

Above medical history was provided by patient, parent or legal guardian.

Signature _____ Date _____

PLEASE FILL OUT OTHER SIDE IF PROCEDURE IS WITH CONTRAST →

Have you had MRI contrast previously? Any reaction? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you allergic to latex or adhesive tape?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have epilepsy or are you prone to seizures?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you diabetic?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a history of multiple myeloma?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a history of scleroderma, lupus, rheumatoid arthritis, polymyositis, or dermatomyositis?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you currently taking Gentamicin, Neomycin, Kanamycin, Streptomycin, Amikacin, Topbramycin, and Amphotericin B?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you been using the following medications daily for at least one month? Ibuprofen (Motrin & Advil), Naproxen (Aleve), or other NSAIDs (Non-Steroidal Anti-Inflammatory Drugs)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you or have you ever had kidney problems?	Yes <input type="checkbox"/> No <input type="checkbox"/> **if yes answer question below**
If yes, what type of kidney problems have you had? 	

I understand this MRI procedure may require the use of MRI contrast. There is a very small risk of having an allergic reaction associated with use of this contrast. These symptoms can range from hives and itching to anaphylactic shock and possible death. By signing I give the technologist permission to administer contrast.

SIGNATURE OF PATIENT _____
PARENT, OR GUARDIAN _____ DATE _____

To Be Completed by Staff

1. Was the medication list screened? Yes No
2. Patient cannot communicate history, general debility or increased risk of aspiration? Yes No
3. Hemodynamically unstable or acute trauma? Yes No