



MRI EXTREMITY (JOINT) QUESTIONNAIRE

PATIENT NAME _____

DATE _____ DATE OF BIRTH _____

What joint/area are we scanning today? _____ Right () Left ()

Do you have pain? Yes () No ()

Where is your pain? _____

What were you doing when the pain started (was there a specific injury)? _____

How long have you had the pain (date of injury)? _____

Do you have:

- Locking? Yes () No ()
- Instability/joint gives out? Yes () No ()
- Poor range of motion? Yes () No ()
- Other symptoms? Yes () No () If Yes, explain _____

Have you had arthroscopy or surgery in the area we are scanning? ____ Yes ____ No

If yes, when and what did they do? _____

Do you have any other medical conditions that may be related to your problem? _____

Have you had any other previous studies for this problem?

MRI Yes() No() Date ___/___/___ Where? _____

CT Yes() No() Date ___/___/___ Where? _____

X-Ray Yes() No() Date ___/___/___ Where? _____

Bone Scan Yes() No() Date ___/___/___ Where? _____



Superior Care through Advanced Technology

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date ___/___/___ Referring Physician _____

Name _____ Age _____ Height _____ Weight _____
Last name First name Middle Initial

Date of Birth ___/___/___ Male [] Female [] Body Part to be Examined _____
month day year

Reason for MRI and/or Symptoms _____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? [] No [] Yes
If yes, please indicate the date and type of surgery:
Date ___/___/___ Type of surgery _____
Date ___/___/___ Type of surgery _____

Table with 4 columns: Imaging type (MRI, CT/CAT Scan, X-Ray, Ultrasound, Nuclear Medicine, Other), Body part, Date, Facility. Includes checkboxes for No/Yes.

3. Have you experienced any problem related to a previous MRI examination or MR procedure? [] No [] Yes
If yes, please describe: _____

4. Have you had an 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 ever 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 medication or drug? [] No [] Yes
If yes, please list: _____

7. Are you allergic to any medication? [] 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, a history of renal (kidney) disease, or seizures? [] No [] Yes
If yes, please describe: _____

For 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 oral contraceptives or receiving hormonal treatment? [] No [] Yes

13. 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

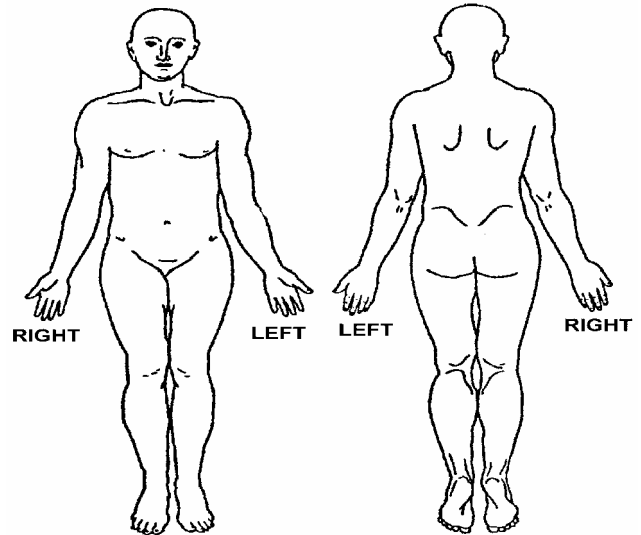


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

- Yes No Aneurysm clip(s)
- Yes No Cardiac pacemaker
- Yes No Implanted cardioverter defibrillator (ICD)
- Yes No Electronic implant or device
- Yes No Magnetically-activated implant or device
- Yes No Neurostimulation system
- Yes No Spinal cord stimulator
- Yes No Internal electrodes or wires
- Yes No Bone growth/bone fusion stimulator
- Yes No Cochlear, otologic, or other ear implant
- Yes No Insulin or other infusion pump
- Yes No Implanted drug infusion device
- Yes No Any type of prosthesis (eye, penile, etc.)
- Yes No Heart valve prosthesis
- Yes No Eyelid spring or wire
- Yes No Artificial or prosthetic limb
- Yes No Metallic stent, filter, or coil
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheter
- Yes No Radiation seeds or implants
- Yes No Swan-Ganz or thermodilution catheter
- Yes No Medication patch (Nicotine, Nitroglycerine)
- Yes No Any metallic fragment or foreign body
- Yes No Wire mesh implant
- Yes No Tissue expander (e.g., breast)
- Yes No Surgical staples, clips, or metallic sutures
- Yes No Joint replacement (hip, knee, etc.)
- Yes No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes No IUD, diaphragm, or pessary
- Yes No Dentures or partial plates
- Yes No Tattoo or permanent makeup
- Yes No Body piercing jewelry
- Yes No Hearing aid
(Remove before entering MR system room)
- Yes No Other implant _____
- Yes No Breathing problem or motion disorder
- Yes No Claustrophobia

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



 **IMPORTANT INSTRUCTIONS**

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

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

Signature of Person Completing Form: _____
Signature

Date ____/____/____

Form Completed By: Patient Relative Nurse _____

Print name

Relationship to patient

Form Information Reviewed By: _____
Print name Signature