MD Imaging
a Rezolut partner

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?_____

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 _____
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ❒ No ❒ Yes
   If yes, please list:

	Body part	Date	Facility
MRI	_____	_____/_____/_____	_____
CT/CAT Scan	_____	_____/_____/_____	_____
X-Ray	_____	_____/_____/_____	_____
Ultrasound	_____	_____/_____/_____	_____
Nuclear Medicine	_____	_____/_____/_____	_____
Other_____	_____	_____/_____/_____	_____

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:

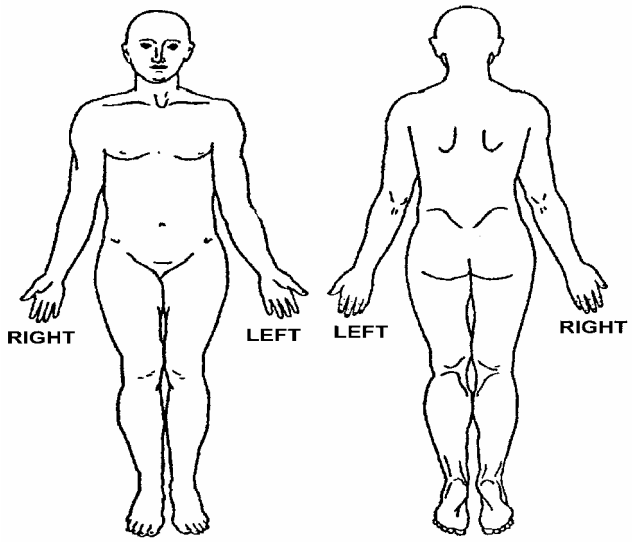
10. Date of last menstrual period:_____/_____/_____ Post menopausal? ❒ No ❒ Yes
11. Are you pregnant or experiencing a late menstrual period? ❒ No ❒ Yes
12. Are you taking oral contraceptives or receiving hormonal treatment? ❒ No ❒ Yes
13. Are you taking any type of fertility medication or having fertility 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: _____ Date _____/_____/_____
Signature

Form Completed By: ❒ Patient ❒ Relative ❒ Nurse _____

_____
Print name Relationship to patient

Form Information Reviewed By: _____
Print name Signature