



MRI EXTREMITY (NON-JOINT) QUESTIONNAIRE

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

What is your present complaint or problem? \_\_\_\_\_

\_\_\_\_\_

How long ago did these symptoms first appear? \_\_\_\_\_

What were you doing when the symptoms started (was there a specific injury)? \_\_\_\_\_

\_\_\_\_\_

Do you have:

Pain? Yes ( ) No ( ) Where? \_\_\_\_\_

A Lump or Mass? Yes ( ) No ( ) Where? \_\_\_\_\_

Cancer? Yes ( ) No ( ) Where? \_\_\_\_\_

Other symptoms? Yes ( ) No ( ) If Yes, explain \_\_\_\_\_

Osteoarthritis? Yes ( ) No ( )

Rheumatoid Arthritis? Yes ( ) No ( )

Lupus? Yes ( ) No ( )

Sickle Cell Anemia? Yes ( ) No ( )

Are you presently taking steroid medication? Yes ( ) No ( )

If Yes, explain \_\_\_\_\_

Have you had 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
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
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? [ ] No [ ] Yes
6. Are you currently taking or have you recently taken any medication or drug? [ ] No [ ] Yes
7. Are you allergic to any medication? [ ] No [ ] Yes
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

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
14. Are you currently breastfeeding? [ ] No [ ] Yes

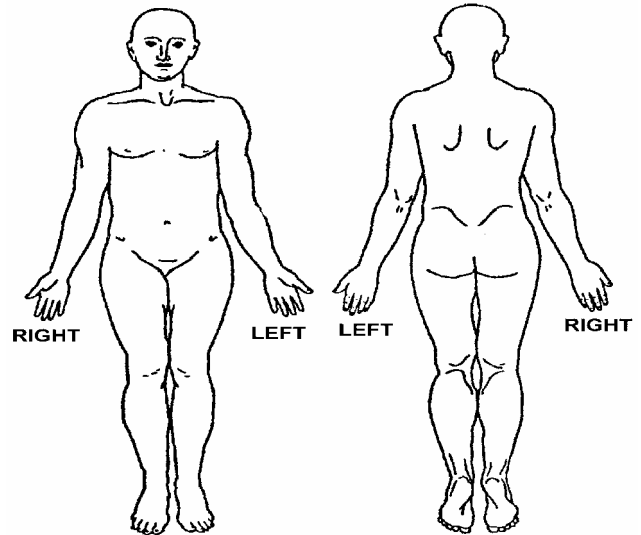


**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object.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