Medical Diagnostic Imaging, LLC *MR Room (Metal) Questionnaire*

TO OUR PATIENTS AND ACCOMPANING FAMILY MEMBERS…

The MR room contains a very strong magnet. Before you are allowed to enter, we must know if you have any metal in your body. Some metal objects can interfere with your scan or may even be dangerous, so PLEASE answer the following questions carefully. If you have a question regarding anything on this form, PLEASE DO NOT HESITATE TO ASK!

Name:_____DOB:__/__/__ Height:_____Weight:_____

☐Yes ☐No Have you ever had surgery of any kind? If yes, please list them all with dates:

_____

_____

☐Yes ☐No Have you ever been diagnosed with cancer? If yes, please describe: _____

☐Yes ☐No Are you claustrophobic?

☐Yes ☐No Are you pregnant, possibly pregnant, or breast feeding? Date of last menstrual cycle: ___/___/___

☐Yes ☐No Have you ever had a metal injury to your eye?

If yes, was it removed from your eye? ☐Yes ☐No

Have you had an MRI since the injury?☐Yes ☐No

Where:_____

Do you have any of these items in your body?

☐Yes ☐No Cardiac pacemaker, pacer wires, or defibrillator

☐Yes ☐No Brain aneurysm clip

☐Yes ☐No Artificial heart valve

☐Yes ☐No Ear implant (cochlear) or Hearing Aides

☐Yes ☐No Eye implant or eyelid spring

☐Yes ☐No Electrical stimulator for nerves or bone (TENS)

☐Yes ☐No Vagal nerve stimulator

☐Yes ☐No Infusion pump or medication patch

☐Yes ☐No Magnetic or electronic implant

☐Yes ☐No Coil, filter, or stent

☐Yes ☐No Any type of prosthesis (eye, ear, limb, penile)

☐Yes ☐No Shunt

☐Yes ☐No Bullets, BBs, pellets or metal shrapnel

☐Yes ☐No Vascular port or any implanted tube or catheter

☐Yes ☐No Removable dental work, dentures, braces, retainers, or implants

☐Yes ☐No Diaphragm or intrauterine device (IUD)

☐Yes ☐No Surgical clips, staples, wire, mesh or stitches

☐Yes ☐No Orthopedic plates, screws, pins, rods, or wires

☐Yes ☐No Tattoo or body piercings

Location(s)_____

Information Concerning Gadolinium Contrast

☐Yes ☐No Have you ever had a previous allergic reaction to gadolinium, MRI contrast dye material?

☐Yes ☐No Do you have any other allergies to food, medicine, etc? If yes, please explain:_____

☐Yes ☐No Do you have a history of asthma or emphysema?

Questions regarding the procedure

Why did the doctor order the MRI? _____

_____

_____

How long has this been going on? _____

_____

Any recent, accidents, injuries, or surgeries?

☐Yes ☐No If yes, please explain_____

_____

Have you had any other tests of the same area?

☐X-Ray ☐US ☐MRI ☐CT

Where/When?_____

_____

Does the patient have a current, or past history of any health problems? _____

_____

_____

For MDI use only:_____

_____

_____

_____

_____ _____

Signature (Parent or Guardian) Date MDI Interviewer Signature Date