**MDI-FRANKLIN** **MDI-GREENFIELD MDI-MILWAUKEE**

 *(MRI, US, CT & X-Ray) (MRI & US) (MRI, US, CT, X-Ray & Fluoro)*

 3111 W Rawson Ave Ste #105 6150 W Layton Ave 8522 W Capitol Dr

 Fax: (414) 301-4501 Fax: (414) 282-4105 Fax: (414) 847-1820

**MR ROOM (METAL) QUESTIONNAIRE**

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| **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:       |
| [ ]  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? |
| **DO YOU HAVE ANY OF THESE ITEMS IN YOUR BODY?** |
| [ ]  Yes  | [ ]  No  | Cardiac pacemaker, pacer wires, or defibrillator | [ ]  Yes  | [ ]  No  | Vascular port or any implanted tube or catheter  |
| [ ]  Yes  | [ ]  No  | Brain aneurysm clip | [ ]  Yes  | [ ]  No  | Any type of prosthesis (eye, ear, limb, penile) |
| [ ]  Yes  | [ ]  No  | Artificial heart valve | [ ]  Yes  | [ ]  No  | Shunt |
| [ ]  Yes  | [ ]  No  | Ear implant (cochlear) or Hearing Aids | [ ]  Yes  | [ ]  No  | Bullets, BBs, pellets or metal shrapnel |
| [ ]  Yes  | [ ]  No  | Electrical stimulator for nerves or bone (TENS) | [ ]  Yes  | [ ]  No  | Removable dental work, **dentures**, braces, retainers, or implants |
| [ ]  Yes  | [ ]  No  | Eye implant or eyelid spring | [ ]  Yes  | [ ]  No  | Diaphragm or intrauterine device (IUD) |
| [ ]  Yes  | [ ]  No  | Vagal nerve stimulator | [ ]  Yes  | [ ]  No  | Surgical clips, staples, wire, mesh or stitches |
| [ ]  Yes  | [ ]  No  | Infusion pump or medication patch | [ ]  Yes  | [ ]  No  | Orthopedic plates, screws, pins, rods, or wires |
| [ ]  Yes  | [ ]  No  | Magnetic or electronic implant | [ ]  Yes  | [ ]  No  | Tattoo or body piercings: Location       |
| [ ]  Yes  | [ ]  No  | Coil, filter, or stent |
| **TO BE COMPLETED BY MRI TECHNOLOGIST:** |
| 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?  | [ ]  Xray [ ]  US [ ]  MRI [ ]  CT  |
| [ ]  Other:       |
| Where/When?       |
|  |
| Patient Signature or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| MDI Interviewer Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

03.06.18