



# MRI PATIENT QUESTIONNAIRE

For Office Use Only  
Place Patient ID label here

Patient name \_\_\_\_\_ Weight \_\_\_\_\_  Female  Male

Exam requested \_\_\_\_\_ Exam date \_\_\_\_\_

Why are you having this examination (medical problem) including symptoms? \_\_\_\_\_

List other imaging studies you have had regarding this problem and where they were performed (if applicable):

- CT \_\_\_\_\_  X-ray \_\_\_\_\_  Ultrasound \_\_\_\_\_
- MRI \_\_\_\_\_  Nuclear Medicine/PET \_\_\_\_\_  Other \_\_\_\_\_

What were the results? \_\_\_\_\_

Did you bring a copy of the results and films? \_\_\_\_\_

History and dates of all prior surgeries: \_\_\_\_\_

What medications do you take? \_\_\_\_\_

For female patients only: Date of last menstrual period \_\_\_\_\_

- Y  N Pregnant  Y  N Nursing  Y  N Perimenopausal
- Y  N Possibility of pregnancy  Y  N Postmenopausal  Y  N Irregular menstrual cycles

All patients please complete the following:

- Y  N History of brain aneurysm/surgery? (Notify MRI Technologist)
- Y  N Have you ever received an eye injury from a metal object (metal slivers, shavings, or other metal objects)? If yes, did you seek medical attention and what was found: \_\_\_\_\_
- Y  N Have you ever been injured by a metal object or foreign body (bullet, BB, shrapnel)?
- Y  N History of kidney problems (decreased renal function, renal failure or dialysis)?
- Y  N Are you currently wearing a skin patch? (Notify MRI Technologist)
- Y  N Previous allergic reaction to contrast (x-ray, CT or MRI contrast)?
- Y  N Personal history of cancer? Type: \_\_\_\_\_
- Y  N History of diabetes/insulin dependent?
- Y  N Are you claustrophobic?  Y  N History of high blood pressure?
- Y  N Do you have allergies?  Y  N History of asthma or lung disease?
- Y  N History of hepatic (liver) disease?  Y  N Family history of cancer?

If you have answered yes to any of the above questions, please specify: \_\_\_\_\_

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Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Technologist: \_\_\_\_\_ Date: \_\_\_\_\_