MIDDLETOWN MEDICAL IMAGING

MRI QUESTIONNAIRE

APPOINTMENT DATE: _____ **APPT. TIME** _____ **ARRIVAL TIME:** _____
Do You Have A Follow-up Appt. with your Doctor? _____ ***When?***_____

Patient's Name _____ **DOB**_____ (**Circle)** Male/Female

Type of Scan_____ R/O_____ **Height** _____ **Weight** _____

Referring Physician _____ **Phone #**_____

SAFETY QUESTIONS	
Do you have a Pacemaker/Defibrillator	☐ YES ☐ NO ☐ N/A
Do you have aneurysm clips	☐ YES ☐ NO ☐ N/A
Have you ever had metal go into or removed from your eyes	☐ YES ☐ NO ☐ N/A
Are you a welder, sheet metal worker or grind with metal	☐ YES ☐ NO ☐ N/A
Have you ever had any ☐ BRAIN ☐ HEART ☐ EAR/EYE surgery	☐ YES ☐ NO ☐ N/A
Have you had any surgery or procedure that left any device, implant, stents, wires or stimulators in your body	☐ YES ☐ NO ☐ N/A WHERE: _____
Do you have a tissue expander implanted	☐ YES ☐ NO ☐ N/A
Do you have removable dentures or hearing aids	☐ YES ☐ NO ☐ N/A
Do you have any tattoo eyeliner	☐ YES ☐ NO ☐ N/A
Are you wearing any medicated patches	☐ YES ☐ NO ☐ N/A
Do you have any metal or mechanical devices hooked up or inside of you	☐ YES ☐ NO ☐ N/A
Are you pregnant	☐ YES ☐ NO ☐ N/A
Can you walk without assistance	☐ YES ☐ NO ☐ N/A EXPLAIN_____

CLINICAL QUESTIONS

Have you had any previous exams of the same body part? **OBTAIN REPORT**	☐ YES ☐ NO ☐ N/A Yes, Where/When: _____
Have you had SURGERY of the body part we are scanning today If YES, what type: _____	☐ YES ☐ NO ☐ N/A
Do you or have you ever had any type of Cancer	☐ YES ☐ NO ☐ N/A Yes, What: _____

CONTRAST QUESTIONS

****PATIENTS NEED TO DRINK AT LEAST 2 8OZ GLASSES OF WATER PRIOR TO EXAM****

Have you had MRI Contrast (Injection) before	☐ YES ☐ NO ☐ N/A Yes, please list any allergic occurrence: _____
Have you been diagnosed with Kidney disease or Kidney failure	☐ YES ☐ NO ☐ N/A
Are you on Dialysis (If so Patient MUST schedule Dialysis after Scan	☐ YES ☐ NO ☐ N/A
Are you Diabetic	☐ YES ☐ NO ☐ N/A

****Any patient with diabetes, kidney failures or over 60 must have blood work. (Labs: BUN, GFR, Creatinine)****

I have reviewed the above information provided in the telephone screening, and it is correct. I hereby give permission to Middletown Medical Imaging to perform this MRI exam.

Patient/Guardian Signature: _____ **Date:** _____

Attachments: ☐ Prior Exam ☐ Blood work ☐ Script

Front Desk Only: Date: _____ **☐ CONFIRMED ☐ LEFT MESSAGE ☐ NO ANSWER**

For Contrast studies: ☐ **instructed patient to drink water**