

**MRI QUESTIONNAIRE- EXTREMITIES OR  
JOINTS**

NAME: \_\_\_\_\_ D.O.B: \_\_\_/\_\_\_/\_\_\_ MR# \_\_\_\_\_

AGE: \_\_\_\_\_ SEX: M/F WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_ft. \_\_\_in.

REFERRING PHYSICIAN: \_\_\_\_\_

• What type of problem are you having? \_\_\_\_\_

• Was this a result of an injury? \_\_\_\_\_

• How long have you had this problem? \_\_\_\_\_

• Do you have a history of being diagnosed with cancer? Yes \_\_\_ No \_\_\_ Type \_\_\_\_\_

• Have you had a stent placement within the last 8 weeks? Yes \_\_\_ No \_\_\_ If yes, when? \_\_\_\_\_

• Have you been treated with either Radiation or Chemotherapy? (If yes, circle) Date Completed \_\_\_\_\_

• Do you have diabetes or any diseases that affect your blood or a history of renal disease? Yes \_\_\_ No \_\_\_

If yes, list \_\_\_\_\_

• Have you had surgery on the area being scanned? Yes \_\_\_ No \_\_\_ If yes, when? \_\_\_\_\_

• Have you had arthroscopy on the area being scanned? Yes \_\_\_ No \_\_\_ If yes, when? \_\_\_\_\_

• Do you have any internal devices or objects implanted in your body? Yes \_\_\_ No \_\_\_ If yes, please describe \_\_\_\_\_

• Do you have any artificial or prosthetic limbs? Yes \_\_\_ No \_\_\_ If yes, please list \_\_\_\_\_

• Do you have a history of contrast reaction or latex allergy? Yes \_\_\_ No \_\_\_ If so, what kind \_\_\_\_\_

• Are you pregnant, breastfeeding or is there a possibility that you might be pregnant? Yes \_\_\_ No \_\_\_

Do you have, or have you ever had any of the following? (If yes, circle)

**PACE MAKER**

**ANEURYSM CLIPS**

**COCHLEAR IMPLANTS**

**HEART VALVE REPLACEMENT**

**NEURO STIMULATOR**

**BODY PIERCING**

**OTHERS (PLEASE SPECIFY) \_\_\_\_\_**

**METAL SLIVERS IN EYES**

**SHRAPNEL (bomb or bullet fragments)**

**HEARING AID**

**REMOVABLE DENTAL WORK/DENTURES**

**CARDIAC DEFIBRILLATOR**

**PENILE IMPLANT**

• Have you had a Bone Scan of this area? Yes \_\_\_ No \_\_\_ Where \_\_\_\_\_ When \_\_\_\_\_

• Have you had MRI, CT or Plain X-rays of this area? Yes \_\_\_ No \_\_\_ Where \_\_\_\_\_ When \_\_\_\_\_

**I acknowledge that all the information given is accurate and thereby consent to have Magnetic Resonance Imaging performed on me.**

**I do not have a pacemaker, brain aneurysm or cardiac defibrillator.**

Date: \_\_\_/\_\_\_/\_\_\_

**Patient's Signature**

**Technologist to Complete Below this Line**

Tech: \_\_\_\_\_ Contrast used: \_\_\_\_\_ / \_\_\_\_\_ cc's Lot # \_\_\_\_\_