

**MRI QUESTIONNAIRE-
CERVICAL/THORACIC/LUMBAR SPINE
SACRUM/ PELVIS**

NAME: _____ D.O.B: ___/___/___ MR# _____

AGE: _____ SEX: M/F WEIGHT: _____ HEIGHT: ___ft. ___in.

REFERRING PHYSICIAN: _____

- Have you had surgery on the area being scanned? _____ When? _____ Where? _____
- 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 ___
- Have you had surgery on your spine, pelvis or sacrum? 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 | METAL SLIVERS IN EYES |
| ANEURYSM CLIPS | SHRAPNEL (bomb or bullet fragments) |
| COCHLEAR IMPLANTS | HEARING AID |
| HEART VALVE REPLACEMENT | REMOVABLE DENTAL WORK/DENTURES |
| NEURO STIMULATOR | CARDIAC DEFIBRILLATOR |
| BODY PIERCING | PENILE IMPLANT |
| OTHER (PLEASE SPECIFY) _____ | |

- Have you had a CAT scan of this area? Yes ___ No ___ Where _____ When _____
- Have you had a MRI of this area? Yes ___ No ___ Where _____ When _____
- Have you had a Bone Scan of this area? Yes ___ No ___ Where _____ When _____
- Have you had 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 clips or cardiac defibrillator.

Date: ___/___/___

Patient's Signature

Technologist to Complete Below this Line

Tech: _____ Contrast used: _____ / _____ cc's Lot # _____