



MRI QUESTIONNAIRE-CHEST/ABDOMEN

NAME: _____ D.O.B: ___/___/___
(Last) (First)

AGE: _____ SEX: M/ F WEIGHT: _____ HEIGHT: _____ ft. _____ in MR#: _____

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 been treated with either Radiation or Chemotherapy? (If yes, circle) Date Completed _____
- Have you ever had surgery on your chest or abdomen? Yes _____ No _____
If yes what type? _____ Date: _____

- **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	REMOVEABLE DENTAL WORK/DENTURES
NEURO STIMULATOR	TATOO'S (over 20 yrs old)
PESSARY (Bladder Support)	IUD
BODY PIERCING	PENILE IMPLANT

- Have you ever had a CT, Ultrasound, or any other imaging studies done of the area being scanned? Yes ___ No ___
If yes, what test/what area? _____
- Have you had any other diagnostics tests on the area that will be scanned today? Yes ___ No ___
If yes, what type of test? _____
- **Are you pregnant, or is there a possibility that you might be pregnant?** Yes ___ No ___
- Do you have a history of allergies? Yes ___ No ___ If so, what kind? _____

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. I have removed all hearing aids and dentures.

_____ Date: ___/___/___
Patient's Signature

Technologist to Complete Below this Line

Rad authorizing IV Contrast: _____ Tech: _____ Study Protocolled By: _____
Contrast Used: _____ / _____ cc's Lot#: _____ Study Checked By: _____