HILLSBOROUGH RADIOLOGY ASSOCIATES, P.A.

MRI QUESTIONNAIRE-**CHEST AND ABDOMEN**

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

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 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)**

PACEMAKER/DEFIBRILLATOR
DIABETES or KIDNEY DISEASE
COCHLEAR IMPLANTS
HEART VALVE REPLACEMENT
TATOOS (over 20 years old)
REMOVABLE DENTAL WORK/DENTURES
ENDOSCOPY CLIPS/INGESTED PILL CAMERA/PH BRAVO CAPSULE
MEDICATION PATCH (birth control/nicotine/Nitroglycerine)
ANY EXTERNAL/INTERNAL PUMPS (i.e., Insulin, chemotherapy)
METAL SLIVERS IN EYES
SHRAPNEL (bomb or bullet fragments)
BREAST TISSUE EXPANDER
NEURO STIMULATOR
PESSARY (bladder support)
IUD
HEARING AID
BODY PIERCING
PENILE IMPLANT
ANEURYSM CLIPS

- Have you ever had a CT Scan, 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? _____
- Do you have a history of allergies? Yes ____ No ____ If so, what kind? _____
- **Are you pregnant, or is there a possibility that you might be pregnant? Yes ____ No ____**

I acknowledge that all the information given is accurate and thereby consent to have Magnetic Resonance Imaging with or without an injection of contrast performed on me. I do not have a pacemaker. I have removed all hearing aids and dentures and any external pumps and monitoring devices.

_____ Date: ____ / ____ / ____ Technologist's Initials: _____
Signature of Patient or Legal Guardian

Technologist to Complete the Section Below

MR # _____ **Designated Physician On-Site:** _____

Tech: _____ **Supervising Physician (if different):** _____

Contrast Used (CIRCLE ONE): **OPTIMARK** **MAGNIVIST** _____ mls Lot #: _____
EOVIST _____ mls Lot #: _____