HILLSBOROUGH RADIOLOGY ASSOCIATES, P.A.

MRI QUESTIONAIRE-**CERVICAL/THORACIC/LUMBAR SPINE**

NAME: _____ D.O.B: ____ / _____ / _____

(Last) (First)

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

REFERRING PHYSICIAN: _____

- What type of problem are you having? _____ Left or Right Side
- 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 had any previous surgery on your spine? Yes ___ No ___ When _____

  If yes, do you know at which levels? _____
- Have you had a spinal injection? Yes ___ No ___ When _____ Type _____
- Do you have pain, numbness, weakness or tingling? (Circle) Where _____

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

PACEMAKER/DEFIBRILLATOR	**METAL SLIVERS IN EYES**	**IUD**
DIABETES or KIDNEY DISEASE	**SHRAPNEL (bomb or bullet fragments)**	**HEARING AID**
COCHLEAR IMPLANTS	**BREAST TISSUE EXPANDER**	**BODY PIERCING**
HEART VALVE REPLACEMENT	**NEURO STIMULATOR**	**PENILE IMPLANT**
TATOOS (over 20 years old)	**PESSARY (bladder support)**	**ANEURYSM CLIPS**
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)		

- Have you had a previous MRI of this area? Yes ____ No_____ Where _____ When _____
- Have you had a CAT scan of this area? Yes ____ No_____ Where_____ When _____
- Have you had a Myelogram 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 _____
- 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: **OPTIMARK** / _____ mls Lot # _____