HILLSBOROUGH RADIOLOGY ASSOCIATES

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? _____
- Which side? Rt ____ Lt _____
- 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? Where_____
- **Do you have, or have you ever had, any of the following?: (If yes, circle)**

PACE MAKER/DEFIBRILLATOR	**METAL SLIVERS IN EYES**
ANEURYSM or ENDOSCOPY 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**
DIABETES or KIDNEY DISEASE	**MEDICATION PATCH(Birth Control/Nicotine/Nitroglycerine)**

- Have you had a CT/MRI 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 X-rays of this area? Yes____ No_____ Where_____ When_____

- 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 with or without an injection of contrast performed on me. I do not have a pacemaker. I have removed all hearing aids and dentures.

_____ **Date:___/____/____** **Technologist Initials:** _____
Patient's Signature **Verified Checked Initials:** _____

TECHNOLOGIST TO COMPLETE Below This Line

Rad authorizing IV Contrast: _____ Tech: _____ Study **Protocoled** by: _____

Contrast used (circle): **OptiMark** Volume: _____ cc's Lot #: _____ Study **Checked** by: _____