HILLSBOROUGH RADIOLOGY ASSOCIATES, P.A.
MRI QUESTIONAIRE-**EXTREMITY**

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

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

REFERRING PHYSICIAN: _____

- Which extremity will be scanned today? _____
- 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 had any surgery on the area being scanned? Yes ____ No ____
  If Yes, when and what type? _____
- Have you ever had arthroscopy on the area being scanned? Yes ____ No ____
  If yes, explain results _____
- Have you had an injection of the area being scanned? Yes ____ No ____ When _____
- Type of injection: _____
- **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 any recent x-rays of this area? Yes ___ No ___ Where _____
- Have you ever had a bone scan? Yes ___ No ___
  If yes, where and 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 # _____