



MRI QUESTIONNAIRE-EXTREMITY

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

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? Y ___ N ___
If Yes, when and what type? _____
- Have you ever had arthroscopy on the area being scanned? Y ___ N ___
If Yes, explain results _____
- Have you had an injection of the area being scanned? Y ___ N ___ When _____
Type of injection _____

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) |
| BODY PIERCING | PENILE IMPLANT |
| DIABETES or KIDNEY DISEASE | MEDICATION PATCH (BirthControl/Nicotine/Nitroglycerine) |

- Have you had any recent x-rays of this area? Y ___ N ___ Where? _____
- Have you ever had a bone scan, CT/MRI scan, ultrasound? Y ___ N ___
If yes, where and 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.

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

TECHNOLOGIST TO COMPLETE Below This Line

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

Contrast used: **OptiMark**-Volume: _____ cc's Lot#: _____ Study **Checked** by: _____
Arthrogram Contrast Mixture: Gad/Saline: _____ cc's OptiRay 300: _____ cc's Lot#: _____