



**MRI QUESTIONNAIRE-NECK**

NAME: \_\_\_\_\_ D.O.B: \_\_\_/\_\_\_/\_\_\_  
 (Last) (First)

AGE: \_\_\_\_\_ SEX: M/ F WEIGHT \_\_\_\_\_ HEIGHT: \_\_\_\_\_ ft. \_\_\_\_\_ in

REFERRING PHYSICIAN: \_\_\_\_\_

- What type of problem are you having? \_\_\_\_\_
- How long have you had this problem? \_\_\_\_\_
- Is there a lump in your neck? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, has it been biopsied? Yes \_\_\_\_\_ No \_\_\_\_\_
- Do have known or suspected problem with the blood circulation in the arteries of your neck?  
 Yes \_\_\_\_\_ No \_\_\_\_\_
- Was this a result of an injury? \_\_\_\_\_ Date of injury \_\_\_\_\_
- 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 neck? Yes \_\_\_\_\_ No \_\_\_\_\_ Which side? Rt \_\_\_\_\_ Lt \_\_\_\_\_  
 If yes, please describe what was done \_\_\_\_\_
- **Do you have, or have you ever had, any of the following?: (If yes, circle)**

- |                                    |                                                                 |
|------------------------------------|-----------------------------------------------------------------|
| <b>PACE MAKER/DEFIBRILLATOR</b>    | <b>METAL SLIVERS IN EYES</b>                                    |
| <b>ANEURYSM or ENDOSCOPY CLIPS</b> | <b>SHRAPNEL (bomb or bullet fragments)</b>                      |
| <b>COCHLEAR IMPLANTS</b>           | <b>HEARING AID</b>                                              |
| <b>HEART VALVE REPLACEMENT</b>     | <b>REMOVEABLE DENTAL WORK/DENTURES</b>                          |
| <b>NEURO STIMULATOR</b>            | <b>TATOO'S (over 20 yrs old)</b>                                |
| <b>BODY PIERCING</b>               | <b>PENILE IMPLANT</b>                                           |
| <b>DIABETES or KIDNEY DISEASE</b>  | <b>MEDICATION PATCH (Birth Control/Nicotine/Nitroglycerine)</b> |

- Have you ever had an ultrasound? Yes \_\_\_\_\_ No \_\_\_\_\_ When \_\_\_\_\_ Where \_\_\_\_\_
- Have you ever had any other x-rays or imaging tests of this area? (MRI/CT?) Yes \_\_\_\_\_ No \_\_\_\_\_  
 What type? \_\_\_\_\_ When \_\_\_\_\_ Where \_\_\_\_\_
- 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 **Protooled** by: \_\_\_\_\_

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