HILLSBOROUGH RADIOLOGY ASSOCIATES, P.A.
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 you have known or suspected problems 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? Right _____ Left _____

  If yes, please describe what was done _____
- **Do you have, or have you ever had, any of the following?: (If yes, circle)**

PACEMAKER/DEFIBRILLATOR
DIABETES or KIDNEY DISEASE
COCHLEAR IMPLANTS
HEART VALVE REPLACEMENT
TATOOS (over 20 years old)
REMOVABLE DENTAL WORK/DENTURES
METAL SLIVERS IN EYES
SHRAPNEL (bomb or bullet fragments)
BREAST TISSUE EXPANDER
NEURO STIMULATOR
PESSARY (bladder support)
IUD
HEARING AID
BODY PIERCING
PENILE IMPLANT
ANEURYSM CLIPS
ENDOSCOPY CLIPS/INGESTED PILL CAMERA/PH BRAVO CAPSULE
MEDICATION PATCH (birth control/nicotine/Nitroglycerine)
ANY EXTERNAL/INTERNAL PUMPS (i.e., Insulin, chemotherapy)

- 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 _____
- 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 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

Contrast Used: **OPTIMARK** / _____ mls Lot # _____
MR # _____ **Designated Physician On-Site:** _____
Tech: _____ **Supervising Physician (if different):** _____