MRI QUESTIONNAIRE - **TMJ**

NAME: _____ D.O.B:___/____/___ AGE: ____ SEX: M/ F
(Last) (First)

WT: ____ lbs HT:___ft.___in REFERRING PHYSICIAN:_____

- Please provide a summary of your symptoms specific to your exam today? _____

  _____
- The symptoms primarily involve what part of your body? _____

  If applicable, please circle: RIGHT or LEFT or BOTH sides of your body and/or UPPER or LOWER part of abdomen.
- Did this symptom/condition arise suddenly? Yes ___ No ___ When did the problem start? _____
- How long have you been treated for this problem? _____ Circle if problem is: Chronic or Acute or Temporary
- Is this your initial visit or follow-up visit? _____
- What is/was the cause of the problem? Accident Motor Vehicle Fall Work-Related Injury (Complete injury form)
- Are you having any pain? Yes___ No___ If Yes, circle if pain is severe or moderate or mild.

  If Yes, circle if pain is generalized or localized. If localized pain, describe specific area of pain? _____
- Do you have any swelling or bruising or inflammation or contusion or sprain or open wound (please circle, if applicable)?
- Did any existing disease/condition attribute to this current symptom/condition? _____
- Do you have a history of being diagnosed with cancer? Yes___ No____ When? _____ Type _____
- Have you been treated with either Radiation or Chemotherapy? (If yes, circle) Date Started _____ Completed _____
- Any surgery on area to be imaged? Y____ N____ If Yes, when and what type?

  _____
- Please circle only those that apply to you and circle the affected:

Clicking	Lt	Rt	Headaches	Lt	Rt	Pain	Lt	Rt
Locking	Lt	Rt	Facial Pain	Lt	Rt	Difficulty opening and		
Crepitus	Lt	Rt	Limited Motion	Lt	Rt	closing your mouth?	Lt	Rt
(grating sound)			Pain in Teeth	Lt	Rt			

- Have you had any previous treatment? (If yes, circle) Splint Therapy Arthroscopy TMJ Surgery
- Have you had any previous exams? (If yes, circle) Panorex Tomograms Arthrograms CT Scan MRI
- Any other medical or family history pertaining to your exam being performed today? _____
- **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 **STENTS**
ENDOSCOPY CLIPS/INGESTED PILL CAMERA/PH BRAVO CAPSULE **BRACES**
MEDICATION PATCH (birth control/nicotine/Nitroglycerine) **HISTORY OF EAR TUBES**
ANY EXTERNAL/INTERNAL PUMPS (i.e., Insulin, chemotherapy)

- Have you ever had a CT Scan, Ultrasound or any other imaging studies done of the area being scanned? Yes____ No_____
  If yes, what test/what area? _____
- Are you pregnant or possibly 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, dentures, any external pumps and monitoring devices.

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