



MRI QUESTIONNAIRE-TMJ

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

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

REFERRING PHYSICIAN: _____

- What type of problem are you having? _____
- Was this a result of any 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 _____
- **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(Birth Control/Nicotine/Nitroglycerine) |

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

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

- Have you had any previous treatment? Splint Therapy Arthroscopy TMJ Surgery
- Have you had any previous exams? Panorex Tomograms Arthrograms CT Scan MRI
- 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 (circle): **OptiMark** Volume: _____ cc's Lot#: _____ Study **Checked** by: _____