IMAGECARE, LLC

MRI PATIENT QUESTIONNAIRE

"PLEASE REMOVE ALL JEWELRY, HAIRPINS, AND HEARING AIDS BEFORE EXAM"

Patient Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____

Have you ever had an MRI Examination? Yes: ____ No: ____ If yes, where: _____

Give a brief history of why you are having this examination: _____

_____

If this is an extremity please circle appropriate: Right Left Both

Please check appropriate answer if you have any of the following:

___ Yes ___ No **A piece of metal in or removed from your eye**

___ Yes ___ No **Shrapnel Injury**

___ Yes ___ No **Brain Surgery**

___ Yes ___ No **Aneurysm Clips**

___ Yes ___ No **Shunt**

___ Yes ___ No **Artificial Heart Valve**

___ Yes ___ No **Pacemaker or Defibrillator**

___ Yes ___ No **Stents, Coils, Filters**

___ Yes ___ No **Tattoo**

___ Yes ___ No **Body Piercing**

___ Yes ___ No **Implanted Electronic Device**(i.e. pain pump, Bone Stimulator, spinal cord stimulator, or Insulin Pump

___ Yes ___ No **Personal History of Cancer**

___ Yes ___ No **Personal History of Kidney Disease**

___ Yes ___ No **Diagnosed as Diabetic**

___ Yes ___ No **Diagnosed with High Blood Pressure**

___ Yes ___ No **Diagnosed with Sickle Cell Anemia**

___ Yes ___ No **Ear implant**

___ Yes ___ No **Eyelid Spring**

___ Yes ___ No **Penile Implants/Prosthesis**

___ Yes ___ No **Artificial Limb**

___ Yes ___ No **Implanted Drug Pump**

___ Yes ___ No **Medication Patch**

___ Yes ___ No **Tissue Expander**

___ Yes ___ No **Wig, Hair Piece**

___ Yes ___ No **Hearing Aid**

___ Yes ___ No **Bullets, Pellets, BB's**

___ Yes ___ No **Are you Claustrophobic**

___ Yes ___ No **Have you ever taken an Endoscopy Camera Pill**

If yes, date: _____

Females Only:

___ Yes ___ No Any possibility of Pregnancy?

Date of last Menstrual Cycle: _____

___Yes ___ No Breast Feeding

Please list any Allergies: _____

Please list any surgeries with dates: _____

_____

ImageCare is providing you with a CD of their images at **NO CHARGE** today. This CD will become your property to **keep** as part of **your medical record**. **This CD should be taken to follow up appointment with your physician. DO NOT RETURN THE CD TO IMAGECARE.** **Patient Initials: _____**

If you require an ADDITIONAL CD of the same images in the future, you will be asked to pay $20.00.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents and I have had the opportunity to ask questions regarding the information on this form.

Patient Signature: _____ Date: _____

Technologist Comments: _____

Technologist Signature: _____ Date: _____