WASHINGTON RADIOLOGY

Demographic Label

MRI Patient History and Safety Questionnaire

Date: ____/____/_____

Patient Name: _____ Age: _____ Weight: _____

Date of Birth: ___/___/_____ ☐ Male ☐ Female Body Part to be Examined: _____

Reason for MRI and/or Symptoms: _____

_____

1. Are you claustrophobic? ☐ No ☐ Yes
2. Have you had prior surgery, or an operation of any kind related to this MRI? ☐ No ☐ Yes
   If yes, please indicate the date and type of surgery:
   Date: ___/___/_____ Type of surgery: _____
3. Have you had cancer? ☐ No ☐ Yes
   If yes, please indicate the date and type of cancer:
   Date: ___/___/_____ Type of Cancer: _____
4. Have you had a prior diagnostic imaging study (e.g. MRI, CT, X-ray, etc.) regarding this problem? ☐ No ☐ Yes

If yes, please list:	**Body Part**	**Date**	**Facility**
MRI:	_____	___/___/_____	_____
CT/CAT Scan:	_____	___/___/_____	_____
X-Ray:	_____	___/___/_____	_____
Ultrasound:	_____	___/___/_____	_____
Nuclear Medicine:	_____	___/___/_____	_____
Other:	_____	___/___/_____	_____

5. Have you been injured, including injury to the eye, by a metallic object, fragment or foreign body (e.g. metallic slivers, shavings, BB bullet, shrapnel, etc.)? ☐ No ☐ Yes
   If yes, please describe: _____
6. Are you currently taking any medications, prescription or over-the-counter? ☐ No ☐ Yes
   If yes, please list: _____
7. Do you have any allergies? ☐ No ☐ Yes
   If yes, please list: _____
8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to MRI contrast? ☐ No ☐ Yes
9. Are you currently on hemodialysis? ☐ No ☐ Yes

FOR FEMALE PATIENTS:

10. Date of last menstrual period: ___/____/_____ Post-menopausal? ☐ No ☐ Yes
11. Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes
12. Are you taking oral contraceptives or receiving hormonal treatment? ☐ No ☐ Yes
13. Are you currently breastfeeding? ☐ No ☐ Yes

FOR OFFICE USE ONLY

Remarks: _____

_____

_____

_____ _____

Technologist Print Name Technologist Signature

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WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

IMPORTANT INSTRUCTIONS

1. Before entering the MR environment or MR system room, you must remove **all** metallic objects including hearing aids, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.
2. You will be asked to use earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.
3. Remove all clothing and wear gown provided, as instructed by personnel.
4. Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

Please indicate if you have any of the following:

- ☐ No ☐ Yes Aneurysm Clip(s)
- ☐ No ☐ Yes Cardiac pacemaker
- ☐ No ☐ Yes Implanted cardioverted defibrillator (ICD)
- ☐ No ☐ Yes Electronic implant or device
- ☐ No ☐ Yes Magnetically-activated implant or device
- ☐ No ☐ Yes Neurostimulation system
- ☐ No ☐ Yes Spinal cord stimulator
- ☐ No ☐ Yes Internal electrodes or wires
- ☐ No ☐ Yes Bone growth/bone fusion stimulator
- ☐ No ☐ Yes Cochlear, otologic, or other ear implant
- ☐ No ☐ Yes Insulin or other infusion pump
- ☐ No ☐ Yes Implanted drug infusion device
- ☐ No ☐ Yes Any type of prosthesis (eye, penile, etc.)
- ☐ No ☐ Yes Heart valve prosthesis
- ☐ No ☐ Yes Eyelid spring or wire
- ☐ No ☐ Yes Artificial or prosthetic limb
- ☐ No ☐ Yes Metallic stent, filter, or coil
- ☐ No ☐ Yes Other: _____
- ☐ No ☐ Yes Shunt (spinal or intraventricular)
- ☐ No ☐ Yes Vascular access port and/or catheter
- ☐ No ☐ Yes Radiation seeds or implants
- ☐ No ☐ Yes Swan-Ganz or thermodilution catheter
- ☐ No ☐ Yes Medication patch (Nicotine)
- ☐ No ☐ Yes Any metallic fragment or foreign body
- ☐ No ☐ Yes Wire mesh implant
- ☐ No ☐ Yes Tissue expander (e.g. breast)
- ☐ No ☐ Yes Surgical staples, clips, or metallic sutures
- ☐ No ☐ Yes Joint replacement (hip, knee, etc.)
- ☐ No ☐ Yes Bone/joint pin, screw, nail, wire, plate
- ☐ No ☐ Yes IUD, diaphragm, or pessary
- ☐ No ☐ Yes Dentures or partial plates
- ☐ No ☐ Yes Tattoo or permanent makeup
- ☐ No ☐ Yes Body piercing jewelry
- ☐ No ☐ Yes Hearing aid (must remove)
- ☐ No ☐ Yes Wig or hair implants

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

Person Completing Form: _____ Date: ____/____/_____

Signature

Form Completed By: ☐ Patient ☐ Guardian _____ _____

Print Name Relationship to patient