

MINOR & JAMES MEDICAL



Patient :

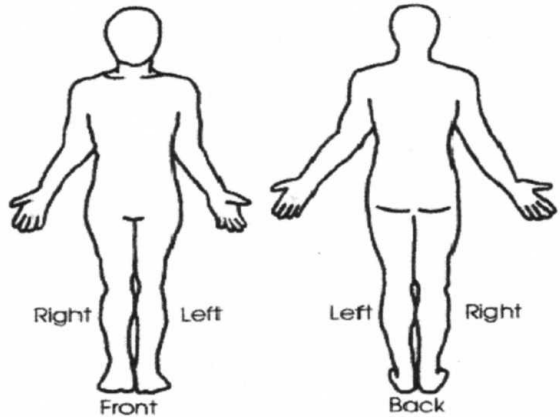
MRN # :

Date :

MRI PATIENT QUESTIONNAIRE AND CONSENT FORM

Describe your symptoms and when did they start?

_____ Weight (lbs) _____



What treatment, including surgery have you received for this so far?

Have you ever had any type of cancer? If so, what type and when?

	Yes	No	
Do you have any known allergies?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list: _____
Do you have asthma or emphysema?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use prescribed medications?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list: _____
Do you have heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have multiple myeloma, sickle cell disease, or polycythemia?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what type? _____
Do you have kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	Do you take insulin for your diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No

Have you had any of the following tests that pertain to the area we are imaging today?

	Facility	Approximate Date
Bone Scan	_____	_____
CT Scan	_____	_____
X-Rays	_____	_____
Ultrasound	_____	_____
MRI	_____	_____

When is your follow up appointment?

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You are scheduled for an MRI exam. Because you will be in the presence of a strong magnetic field, it is very important that we are aware of **ANY METALLIC OBJECTS** that have been surgically implanted into your body. An accurate surgical and medical history is needed before we start your test. Please check the following :

	YES	NO		YES	NO
Cardiac Pacemaker/ Pacing Wires	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm Clip	<input type="checkbox"/>	<input type="checkbox"/>
Aortic Clip	<input type="checkbox"/>	<input type="checkbox"/>	Neurostimulator	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic Insulin Pump	<input type="checkbox"/>	<input type="checkbox"/>
Cochlear (ear) implant	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aids	<input type="checkbox"/>	<input type="checkbox"/>
Heart Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacements	<input type="checkbox"/>	<input type="checkbox"/>
Herrington Rods	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Limbs	<input type="checkbox"/>	<input type="checkbox"/>
Wire Sutures	<input type="checkbox"/>	<input type="checkbox"/>	Porta Catheter or Passport	<input type="checkbox"/>	<input type="checkbox"/>
Removable Dental Work	<input type="checkbox"/>	<input type="checkbox"/>	IVC Filter	<input type="checkbox"/>	<input type="checkbox"/>
Shunt	<input type="checkbox"/>	<input type="checkbox"/>	Pain Pump	<input type="checkbox"/>	<input type="checkbox"/>
Metal fragments in eyes	<input type="checkbox"/>	<input type="checkbox"/>	New Tattoos	<input type="checkbox"/>	<input type="checkbox"/>
Wearing a Nicotine Patch	<input type="checkbox"/>	<input type="checkbox"/>	Are you Pregnant or Breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>
Wearing a Medicinal Patch	<input type="checkbox"/>	<input type="checkbox"/>	Are you wearing Magnets	<input type="checkbox"/>	<input type="checkbox"/>
Any other metal in body	<input type="checkbox"/>	<input type="checkbox"/>	Bullets , B.B.s or Pellets	<input type="checkbox"/>	<input type="checkbox"/>
Do you have stents placed	<input type="checkbox"/>	<input type="checkbox"/>	Metal Shrapnel or Fragments	<input type="checkbox"/>	<input type="checkbox"/>
Magnetic Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Coil Filter or Wire in Blood Vessel	<input type="checkbox"/>	<input type="checkbox"/>
Breast Tissue Expanders	<input type="checkbox"/>	<input type="checkbox"/>	Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Stapes Implant	<input type="checkbox"/>	<input type="checkbox"/>			

Consent

Your MRI exam may or may not require an injection of a contrast medium called Gadolinium. This injection would be placed into a vein in your arm. This injection may help the physician more accurately diagnose your condition.

The contrast we use is considered quite safe and complications are rare. However an injection carries a slight risk, including injury to the vein, infection, infiltration or reaction to the material being injected. On rare occasions, more serious reactions can occur. Most reactions are mild, consisting of headaches, nausea, coldness or hives. The physicians and staff of our department are prepared to treat those reactions should they occur.

I have read the above information and have answered them completely. I hereby give my consent to have a Magnetic Resonance Imaging Scan.

Patient Signature _____

Date : _____