OPEN IMAGING OF LONGVIEW

1010 N. 6th Street • Longview, Texas 75601 • (903) 757-9596 • (866) 757-9596

MRI QUESTIONNAIRE

Name: ______________ **Age** ______ **Sex** ______ **WT** ______ **Height** ______

PATIENTS WITH CEREBRAL ANEURYSM CLIPS OR PACEMAKERS CANNOT UNDERGO AN MRI

Describe your symptoms: ______________

Have you ever had an injury to this area? Yes No If so, when? ______

Have you had previous x-rays of this area? Yes No If so, when? ______ Where? ______

Please list all surgeries: ______________

DO YOU HAVE A PACEMAKER? Yes No
IF YES, PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY

Are you currently on dialysis or have chronic renal failure? Yes No

Have you ever worked as a metal worker?
If yes, could you have metal in your head, eyes or skin? Yes No

Do you have metal plates, pins, screws, nails or clips in your body? Yes No

Do you wear a hearing aid? Yes No

Do you have implanted electrical devices? Yes No

Do you have stents or a Heart valve? Yes No

Do you have neurostimulators? Yes No

Could you be pregnant? Date of last menstrual period: ______ Yes No

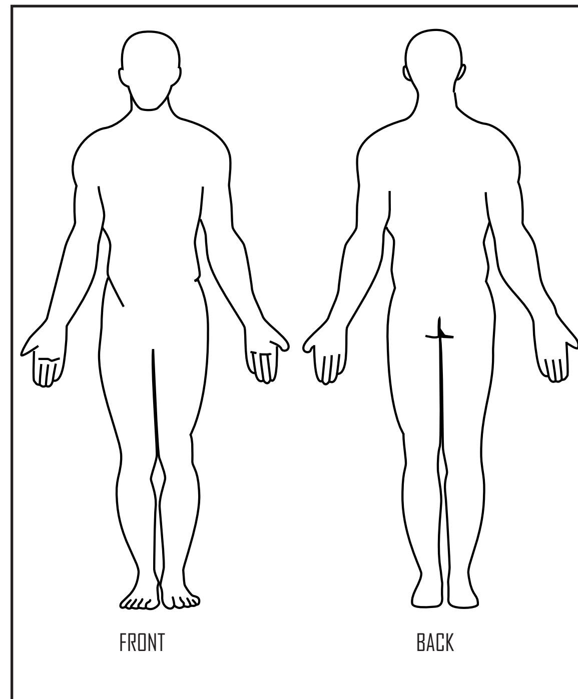
Have you ever had surgery on your head (ex: brain, ears or eyes)? Yes No

Is this procedure being done due to a work-related injury? Yes No

Is this procedure being done due to an automobile accident? Yes No

Do you have numbness or weakness in your arms or legs? Yes No
Please specify: ______________

Do you have pain which radiates into your arms or legs? Yes No
If so, specify right, left, arm or leg: ______________



Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.).

Have you been treated for Iron Deficiency Anemia with Feraheme Injections within last 3 months? Yes No

Do you have any tattoos or body piercings? Yes No

DO YOU HAVE ANY OF THE FOLLOWING?

Headaches Yes No
Dizziness Yes No
Blackouts Yes No
Seizures Yes No
History of stroke Yes No
Hypertension Yes No
Diabetes Yes No

Have you been diagnosed with cancer? Yes No
What type? ______________
Have you had radiation or chemotherapy treatments? Yes No
Last treatment date: ______________
Have you ever had a Liver Transplant? Yes No
Have you ever been diagnosed with severe Hepatic Disease? Yes No

Please list any medical conditions: ______________

Please list any medication allergies: ______________

Signature: ______________ **Date:** ______________

I attest that the above information is correct to the best of my knowledge

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TO BE COMPLETED BY DEPARTMENTAL STAFF

Exam: ______________ Reason for exam: ______________

Contrast type: ______________ Amount/Rate: ______________ Site: ______________

Technologist: ______________ Date: ______ # of Images: ______ GFR: ______ $mL/min/1.73m^2$

Creatinine: ______________ Reference Range: .6-1.5 mg/dl