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Magnetic Resonance Imaging (MRI) Questionnaire

Account Number

Date

Patient

SSN

Patient DnR

Height

Weight

Have you had SURGERY on:

YES

NO

Date of Surgery

Eyes or Ears with Implants of Metal?

Bone Surgery With Metal Pins or Screws?

Brain, Heart, Blood Vessel with Metal Clips

Spinal Surgery?

Have you ever had metal cleaned from your eyes?

Drilled

Washed out

Do You Have a Cardiac Pacemaker or Other Internal Device?

Are You Claustrophobic?

W/Sedation

Are You Pregnant?

Have You Ever Had a Gun Shot Wound?

Your MRI is scheduled for:

With:

MIH

RRMC

SCH

OTHER:

Your follow-up appointment with:

Is scheduled on:

Date Patient Instructed

Scheduled and Instructed By

X-rays With Patient

Prescription With Patient