tolland imaging center

MRI SCREENING QUESTIONNAIRE

Patient Name:____

Weight:___________ **DOB:**_______________

Type of MRI ____________________________________

Please list all surgeries & date:

____

____

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1. Have you ever worked as a machinist, metal worker, or welder using iron or steel? Yes No
2. Have you ever had metal in your eyes or removed from your eyes? Yes No
   If yes, please explain:
3. Any chance of pregnancy? Yes No
4. Are you a nursing mother? Yes No
5. Are you claustrophobic? Yes No
6. Have you had a biopsy with clips placed in the last 3 months? Yes No
7. Please list any allergies
8. Do you have a history of kidney disease / renal failure? Yes No
9. Are you on Dialysis? Yes No

Please circle the appropriate answer if you have the following items:

Yes	**No**	**Pacemaker or Pacemaker wires**	**Yes**	**No**	**Penile Implant**
Yes	**No**	**Aneurysm Clips**	**Yes**	**No**	**Joint Replacements (Prosthesis)**
Yes	**No**	**Heart valve prosthesis**	**Yes**	**No**	**Eyelid spring or wire**
Yes	**No**	**Heart Stents**	**Yes**	**No**	**Body Piercing Jewelry**
Yes	**No**	**Infusion Pump**	**Yes**	**No**	**Cochlear Implants (ear)**
Yes	**No**	**Defibrillator**	**Yes**	**No**	**Ocular Implants (eye)**
Yes	**No**	**Insulin Pump/Glucose Sensor**	**Yes**	**No**	**Shrapnel, grenade, mortar, or b.b.**
Yes	**No**	**Medicine Patch**	**Yes**	**No**	**Wire Sutures, staples, clips**
Yes	**No**	**Bone / Joint pin, screw, nail, etc**	**Yes**	**No**	**Removable dentures, false teeth or partials**
Yes	**No**	**Neurostimulators (Tens−Unit)**	**Yes**	**No**	**Braces**
Yes	**No**	**Electrodes**	**Yes**	**No**	**Embolization Coil**
Yes	**No**	**Hearing Aids**	**Yes**	**No**	**Aortic Clips**
Yes	**No**	**Metallic stent, filter, or coils**	**Yes**	**No**	**IV access port (PICC, Hickman, Port-a-cath)**
Yes	**No**	**Radiation seeds or implants**	**Yes**	**No**	**Metal containing clothing material**
Yes	**No**	**IUD**	**Yes**	**No**	**Tattoos / Permanent makeup**
Yes	**No**	**Wire mesh implant**	**Yes**	**No**	**Tissue expander (e.g. breast)**
Yes	**No**	**Shunts, Spinal or Ventricular**	**Yes**	**No**	**Endoscopic pill (camera)**
Yes	**No**	**Other Implants?**__________	**Yes**	**No**	**Electronic monitor/ tagging equipment**

I attest that the information is correct to the best of my knowledge. I have read this form and had the opportunity to ask questions.

Signature of person completing form __________________________ **Date:** ________________

Form completed by: Patient Relative Relation to patient ______________________________

Form reviewed by: ____ **Date:** ________________

Locker will be provided
Before entering the MRI room you MUST remove all metallic objects including hearing aids, dentures, partial plates, keys, cell phone, eyeglasses, jewelry, body piercings, watch, safety pins, paper clips, money clips, credit cards, magnetic strips, cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners fitness trackers, glucose sensors, hair pins, barrettes & clips, wigs, hair implants, and clothing with metallic threads.

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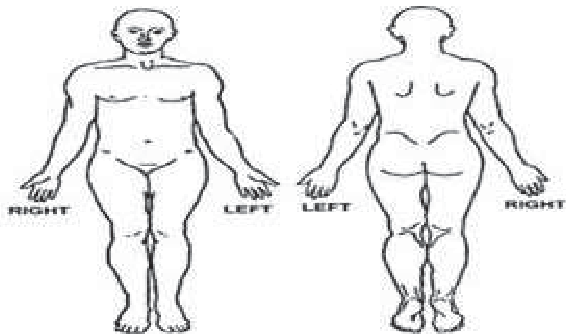

Please circle the area you are experiencing symptoms on the chart below

Please describe the symptoms that has caused your healthcare provider to order a MRI.

____

____

____

How long have you had these symptoms?____

Have you had any previous surgery on the area of interest?____________________________

Have you had any previous imaging studies on the area of interest?______________________

If yes, where and when? ____

Have you had ever had radiation or chemotherapy? ____________________________________

☐ Breast MRI Patients
Date of last menstrual period ________________________
If you have breast implants circle type: Saline Silicone Saline & Silicone

☐ Joint and Extremity Patients (Example: Knee, ankle, shoulder)

☐ Joint Pain ☐ Weakness ☐ Lump or Mass
☐ Immobile ☐ Swelling ☐ Pain

☐ Spine MRI Patients
Have you had previous back surgery?________________________
Please be sure you circled area of symptoms at top of page.
Have you had any problems with bowel or bladder function?__________

☐ Head/Brain MRI Patients
Have you had any of the following symptoms?

☐ Headache Location Left Right Front Back
☐ Hearing Loss Left Right
☐ Blurred Vision Left Right
☐ Vision Loss Left Right
☐ Vertigo / Dizzy Spells Left Right
☐ Weakness Paralysis Left Right Area ______________
☐ Seizure Please Describe ______________________________
Do you have any of the following: Please explain further:
☐ Stroke, Tumor, Seizures, Aneurysm, Head Injury

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Tech Comments____

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