ADIRONDACK RADIOLOGY ASSOCIATES, P.C.
MAGNETIC RESONANCE IMAGING PATIENT QUESTIONNAIRE

PATIENT NAME: _____ DATE/TIME: _____

MR #: _____ DOB: _____

EXAM IS SCHEDULED AT: ☐ Baybrook ☐ NCIC ☐ Open MR of GF ☐ SIC
SCRIPT: Please bring script to appointment if referring clinician gave it to you

MALE: _____ FEMALE: _____ BODY PART TO BE EXAMINED: _____

WEIGHT: _____ HEIGHT: _____ Medical

Allergies_____

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The following items may pose a safety hazard or interfere with MR imaging:

YES NO Cardiac pacemaker/defibrillator **If YES, stop -- check with technologist**
YES NO Internal electrodes or wires **If YES, stop -- check with technologist**
YES NO Brain aneurysm clip Make/Model# _____
YES NO Neurostimulator (TENS unit), bone stimulator, insulin pump, pain pump

Make/Model# _____

YES NO Any prior surgery, if Yes, date/type_____

_____

YES NO Have you had metal particles in or removed from your eyes?
-if yes, were they removed by a doctor? **YES NO**
-if removed, did the doctor tell you they "got it all out"? **YES NO**
YES NO Implants or prostheses (artificial eye, penile implant,cochlear implant)
Make/Model# _____
YES NO Intravascular coil, stent, or filter Type _____ Date _____
YES NO Other shrapnel or bullet fragments **Where?** _____
YES NO Prosthetic heart valve **Year Implanted** _____
Pre 1988 Make/Model# _____
YES NO Eyelid spring or wire Make/Model# _____
YES NO Artificial or prosthetic limb Describe _____
YES NO Shunt (spinal or intraventricular) Make/Model# _____
YES NO Vascular access port and/or catheter Make/Model# _____
YES NO Tissue expander (e.g., breast) Make/Model# _____
YES NO IUD, diaphragm, or pessary Make/Model# _____
YES NO Tattoo or permanent makeup Where? _____
YES NO Body piercing jewelry Where? _____
YES NO Hearing aid Removable? **YES NO**
Tech initial that hearing aid removed prior to scanning _____
YES NO Orthopedic hardware (describe) _____
YES NO Medication Patches? (All medications patches must be removed prior to MRI scanning)

MAGNETIC RESONANCE IMAGING PATIENT QUESTIONNAIRE Page 2

PATIENT NAME: _____ DATE/TIME: _____

MR #: _____ DOB: _____

Previous exams related to current body part being imaged:

	Where	When (approximate)
MRI	_____	_____
CT	_____	_____
X-ray	_____	_____
Ultrasound	_____	_____
Nuclear Med/PET	_____	_____

Patient was advised by ARA staff that prior films must be here for appointment? **YES NO**

YES NO Is your problem the result of a motor vehicle accident or work related injury?
If yes, notify billing if patient not scheduled under Comp or No Fault

YES NO Do you believe you have claustrophobia?
If yes, have you taken medications for claustrophobia? **YES NO**
If yes, is someone accompanying you to drive you home? **YES NO**
YES NO Is there a possibility that you are pregnant?
YES NO Are you currently breast feeding?
YES NO Are you diabetic?
YES NO Do you have uncontrolled high blood pressure?
YES NO Do you have any kidney disease?
If yes kidney disease, are you on renal dialysis? **YES NO**
YES NO Do you have a history of receiving chemotherapy?
YES NO Have you had any recent bloodwork?
If yes, where/when was it done? **YES NO**

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

Signature of Person Completing Form: _____ Date: _____

Relationship to Patient: _____

Form Information Reviewed By: _____

___ MRI Technologist ___ Nurse ___ Radiologist