Express Medical Imaging
MRI Questionnaire

Date:	ID:	DOB:
Name:	Accession:	Weight:

Have you had prior surgery or an operation of any kind? If yes, please list below.			Yes ☐	No ☐
Type:	Date:	Type:	Date:	
Type:	Date:	Type:	Date:	

Have you had any previous diagnostic imaging study or examination? If yes, please indicate the date, bodypart, facility and phone number below.	Yes ☐	No ☐

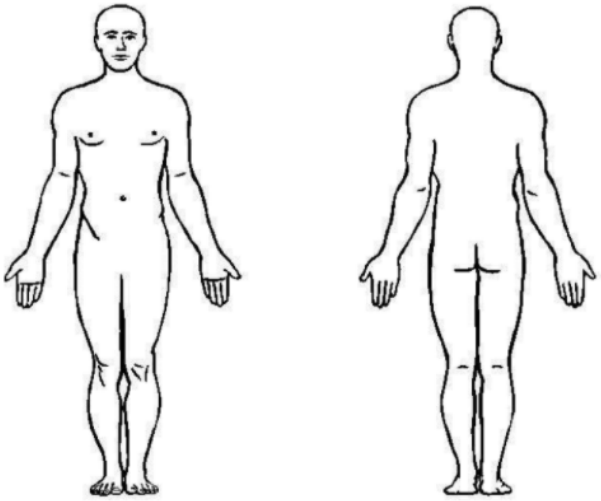
Procedure	Date	Body Part	Facility	Phone
MRI				
CT				
Ultrasound				
Xray				
Nuclear Medicine				
Other				

Have you experienced any problems with a previous MRI examination?	Yes ☐	No ☐
Have you had an injury to the eye involving a metallic object or fragment?	Yes ☐	No ☐
Have you ever been injured by a metallic object anywhere within your body? (BB, Bullet, Shrapnel, etc.)	Yes ☐	No ☐
Have you ever worked as a hobbyist or through employment in a metal shop Tool or dye shop, or handled power tools involved in cutting or welding metal?	Yes ☐	No ☐
Are you currently taking or have recently taken any medications or drugs?	Yes ☐	No ☐
Are you allergic to any medications?	Yes ☐	No ☐
Have you ever an allergic reaction to iodine, or contrast material used for MRI or CT procedures?	Yes ☐	No ☐
Do you have a history of anemia, renal disease, or seizures?	Yes ☐	No ☐
FOR FEMALE PATIENTS ONLY Are you pregnant?	Yes ☐	No ☐

	WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI procedure. DO NOT ENTER the MRI room or environment if you have any questions or concerns regarding an implant, device, or object. Consult the MRI Technologist or Radiologist before entering. The MRI Magnet is ALWAYS on.

Please indicate if you have any of the follow:	Please mark on the figure below, the location of any implants or metal inside of your body:

Aneurysm clip(s)	Yes ☐	No ☐
Cardiac Pacemaker	Yes ☐	No ☐
Implant Defibrillator	Yes ☐	No ☐
Electronic Implanted device	Yes ☐	No ☐
Magnetically-activated device	Yes ☐	No ☐
Neurostimulation system	Yes ☐	No ☐
Spinal cord stimulator	Yes ☐	No ☐
Internal electrodes or wires	Yes ☐	No ☐
Bone growth/fusion stimulator	Yes ☐	No ☐
Cochlear or other ear implant	Yes ☐	No ☐
Insulin or other infusion plump	Yes ☐	No ☐
Drug infusion device	Yes ☐	No ☐
Any type of prosthesis	Yes ☐	No ☐
Heart valve prosthesis	Yes ☐	No ☐
Eyelid spring or wire	Yes ☐	No ☐
Artificial limb	Yes ☐	No ☐
Metallic stent, filter or coil	Yes ☐	No ☐
Shunt (spinal or intraventricular)	Yes ☐	No ☐
Vascular access port	Yes ☐	No ☐
Catheter	Yes ☐	No ☐
Radiation seeds or implant	Yes ☐	No ☐
Medication patch	Yes ☐	No ☐
Wire mesh implant	Yes ☐	No ☐
Tissue expander	Yes ☐	No ☐
Surgical staples, clips, or sutures	Yes ☐	No ☐
Joint replacement	Yes ☐	No ☐
Bone/joint screw, pic, wire, etc	Yes ☐	No ☐
IUD, diaphragm	Yes ☐	No ☐
Denture or partial plates	Yes ☐	No ☐
Tattoo or permanent makeup	Yes ☐	No ☐
Body piercing jewelry	Yes ☐	No ☐
Hearing aid	Yes ☐	No ☐
Breathing problems	Yes ☐	No ☐
Claustrophobia	Yes ☐	No ☐



IMPORTANT INFORMATION

Before entering the MRI environment or system room, you must remove all metallic objects, including hearing aids, denture, partial plates, keys, cell phone, eye glasses, hair pins, jewelry, safety pins, paper clips, credit cards, pocket knife, coins, pens, clothing with metal fasteners or threads.

Please consult the MRI Technologist if you have any questions, BEFORE entering the MRI system room.

NOTE: You may be required to wear ear plugs or other hearing protection during the MRI procedure to prevent possible problems or hazards to acoustic sounds.

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 MRI procedures that I am about to undergo. I acknowledge that EMI is not responsible for any injury or damage that may occur to my body or any device resulting from being in the MRI system room.

Signature of Person Completing Form:	Date
Printed Name:	Form Completed By: Patient Relative Other
MRI Tech Signature:	Printed Name: