



ATLANTIC RADIOLOGIC IMAGING MRI PATIENT QUESTIONNAIRE

Your Name: _____ Acct #: _____

Date of Birth: ____/____/____ Age: ____ Weight: ____ lbs Sex: M F

SOME PEOPLE CANNOT HAVE AN MRI EXAM, THEY CANNOT GO NEAR THE MRI SCANNER

Do you have (or have you ever had) any of the following?

- Y N **A medical device in your body such as a pacemaker**
- Y N **Surgical aneurysm clip in the brain**
- Y N **Metal fragments (or rust) in the eye**
- Y N Any other metal or object in your body (shunt, stent) _____
- Y N Nerve or bone stimulator
- Y N Drug infusapump
- Y N Eye or ear implant
- Y N Transdermal patches *i.e.* nitroglycerin, nicotine, HRT
- Y N Are you pregnant

Technologist's signature: _____

Please describe in your own words your present complaint or problem. How long ago did it start? What does your doctor think is the cause?

Are you here as a result of a CAR ACCIDENT? Y N A WORK ACCIDENT? Y N

If yes, please give us the date of the accident ____/____/____

Please check all the diseases in this list that you have either had in the past, or for which you are now under treatment:

- | | | |
|---|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer* (specify below) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hereditary disease* | <input type="checkbox"/> Immune Deficiency |
| <input type="checkbox"/> Surgery on your head* | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pituitary/Hormone disease |
| <input type="checkbox"/> Stroke/bleeding in brain | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Sickle cell disease | | |

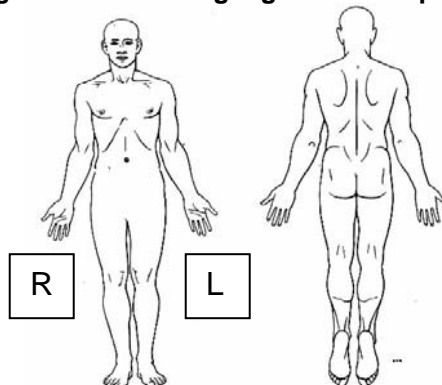
*

Do you have any of the following signs/symptoms or have you had any of the following treatments?

Please check all that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Difficulty-speaking | <input type="checkbox"/> Problems with vision or hearing |
| <input type="checkbox"/> Paralysis/weakness of any body part | <input type="checkbox"/> Fever, night sweats | <input type="checkbox"/> New onset of seizures |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Radiation |

Please shade figures below to highlight areas of pain or discomfort.



To the best of my knowledge the above information is true and correct.

Signed: _____ Date: ____/____/____