Lehigh Magnetic Imaging Center

MEDICAL QUESTIONNAIRE

How do you wish to be addressed by our staff (for example Mary, Mrs. Smith)? ____

Patient Name ____ Height ________ Weight __________ Male Female
Last First Middle initial

Address ____ E-mail address _____________________________________

City ____ Telephone (home) (_______) ___________-_______________

State ________________ Zip code __________________ Telephone (work) (_______) ___________-_______________

Age __________________ Date of birth______/_____ / ______ Telephone (cell) (_______) ___________-_______________

Reason for MRI and/or symptoms ____

In addition to the physician ordering my MRI, send copy of MRI report to ____

My physician has requested a copy of my study on CD. Yes No If yes, please ask the secretary to provide the CD after your MRI scan.

---

1. Have you had a prior surgery or procedure (e.g., arthroscopy, colonoscopy, endoscopy) of any kind? Yes No
If yes, please indicate date and type of surgery or procedure.

Date______/______ / ______ Type _____________________ Date______ / ______ / _______ Type ______________________
Date______/______ / ______ Type _____________________ Date______ / ______ / _______ Type ______________________
Date______/______ / ______ Type _____________________ Date______ / ______ / _______ Type ______________________
Date______/______ / ______ Type _____________________ Date______ / ______ / _______ Type ______________________

2. Have you had a prior diagnostic imaging study or exam (e.g., MRI, CT, Ultrasound, Mammogram, X-Ray) of body part being scanned? Yes No

	Date	Facility
MRI	______ / ______/_______	___________________________________
CT Scan	______ / ______/_______	___________________________________
X-Ray	______ / ______/_______	___________________________________
Mammogram	______ / ______/_______	___________________________________
Ultrasound	______ / ______/_______	___________________________________
Nuclear Medicine	______ / ______/_______	___________________________________
Other _________	______ / ______/_______	___________________________________

3. Have you experienced any problem related to a previous MRI/MRA scan? Yes No
If yes, please describe____

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body) or worked around metal? Yes No
If yes, please describe____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel)? Yes No
If yes, please describe____

6. Have you taken any medication specifically for this test? Yes No
If yes, what ______________________ when _________________________
Have you been advised of any restrictions following this medication? Yes No

7. Are you allergic to any medication? Yes No
If yes, please list ____

8. Do you have a history of asthma or respiratory disease? Yes No

9. Have you had a reaction to a contrast medium or dye used for an MRI, CT or X-Ray examination? If yes, please describe symptoms and medical treatment. Yes No

____

10. Do you have diabetes, anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal failure, kidney transplant, high blood pressure (hypertension), liver (hepatic) disease, liver transplant or seizures? If yes, please describe ____ Yes No

11. Are you pregnant or experiencing a late menstrual period? Yes No

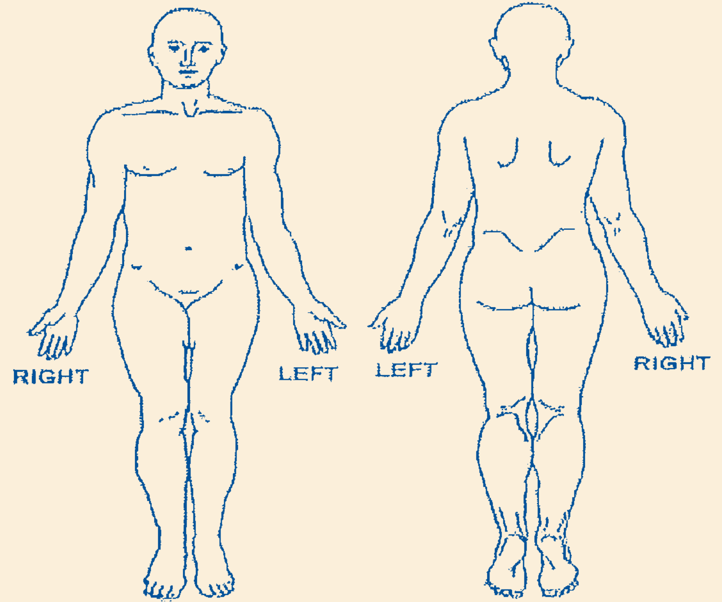
Patient Name ____

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

Please indicate if you have any of the following:

Yes	No	Aneurysm clips
Yes	No	Cardiac pacemaker
Yes	No	Implanted cardioverter defibrillator (ICD)
Yes	No	Electronic implant or device
Yes	No	Magnetically-activated implant or device
Yes	No	Neurostimulation system
Yes	No	Spinal cord stimulator
Yes	No	Internal electrodes or wires
Yes	No	Bone growth/bone fusion stimulator
Yes	No	Cochlear, otologic or other ear implant
Yes	No	Insulin or other infusion pump
Yes	No	Implanted drug infusion device
Yes	No	Any type of prosthesis (e.g., eye, penile)
Yes	No	Heart valve prosthesis
Yes	No	Eyelid spring or wire
Yes	No	Artificial or prosthetic limb
Yes	No	Metallic stent, fiber or coil
Yes	No	Shunt (spinal or intraventricular)
Yes	No	Vascular access port and/or catheter
Yes	No	Radiation seeds or implants
Yes	No	Swan-Ganz or thermodilution catheter
Yes	No	Medication patch (e.g., Nicotine, Nitroglycerine)
Yes	No	Any metallic fragment or foreign body
Yes	No	Wire mesh implant
Yes	No	Tissue expander (e.g., breast)
Yes	No	Surgical staples, clips or metallic sutures
Yes	No	Joint replacement (e.g., hip, knee)
Yes	No	Bone/joint pin, screw, nail, wire, plate
Yes	No	IUD, diaphragm or pessary
Yes	No	Dentures or partial plates
Yes	No	Tattoo or permanent makeup
Yes	No	Body piercing jewelry
Yes	No	Hearing aid
Yes	No	Other implant ____________________
Yes	No	Breathing problem or motion disorder
Yes	No	Claustrophobia
Yes	No	Female patients: are you currently breastfeeding?

Please mark on the figure(s) below the area(s) of concern.



IMPORTANT INSTRUCTIONS

Remove all metallic objects before entering the MR system room or MR environment including hearing aids, beeper, cell phone, keys, eyeglasses, hair pins, barrettes, jewelry (including body piercing jewelry), watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper. Loose metallic objects are especially prohibited in the MR system room and MR environment.

Please consult the MRI technologist if you have any questions or concerns BEFORE you enter the MR system room.

NOTE: You will be required to wear earplugs and/or other hearing protection during the MRI procedure to prevent possible problems or hazards related to acoustic noise.

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 MRI procedure that I am about to undergo.

Patient or authorized signature ______________________________ Date _____/______ / ______

Name and relationship if other than patient ______________________ Patient ______________________

Print name Relationship

For Lehigh Magnetic Imaging Center use only

Form information reviewed by ______________________________________

Signature