Lehigh Magnetic Imaging Center

LEHIGH VALLEY HEALTH NETWORK

The Highlighted Fields are Required

APPOINTMENT QUESTIONNAIRE

Phone 610.740.9500 800.525.9950
Fax 610.740.0288

Patient Name (last, first, middle initial) ______________________ Sex ❑ Male ❑ Female

Address ______________________

Telephone (home) ______________ (work/cell) ______________ E-mail address ______________

Date of birth ______________ Social Security No. ______________ Height ________ Weight ________

Primary insurance ______________ ID no. ______________ Work/Auto related? ❑ Yes ❑ No

Additional claim information is required for workers' compensation or auto cases prior to scheduling

Secondary insurance ______________ ID no. ______________

Doctor ordering MRI ______________ Doctor's phone no. ______________

PATIENT MEDICAL INFORMATION

1. Pacemaker ❑ Yes ❑ No
2. Aneurysm clip in head ❑ Yes ❑ No
3. Metal in eyes or worked with metal ❑ Yes ❑ No
4. Metal anywhere else in body ❑ Yes ❑ No
   Type ______________
   Location ______________
5. Dental braces ❑ Yes ❑ No
6. Previous surgeries ❑ Yes ❑ No
   List all surgeries and dates
   ____
   ____
   ____
   ____
   ____
   ____
7. Clip from G.I. procedure within last two weeks ❑ Yes ❑ No
8. Personal history of cancer ❑ Yes ❑ No
   Type ______________
   Port access ❑ Yes ❑ No
9. Asthma ❑ Yes ❑ No
   Number of attacks in past 2 months ________
10. Severe kidney disease ❑ Yes ❑ No
    Treating doctor ______________
11. Dialysis ❑ Yes ❑ No
    Type ❑ Peritoneal ❑ Hemo
    Schedule M T W T F S am pm
12. Diabetes ❑ Yes ❑ No
13. Previous contrast reaction ❑ Yes ❑ No
    Type contrast ❑ MRI ❑ CT
    Symptoms ______________
    How treated ______________
14. Previous study of body part being scanned ❑ Yes ❑ No
    Type study ______________
    Date of study ______________
    Where performed ______________
    Patient to bring? ❑ Yes ❑ No
15. Medication patches ❑ Yes ❑ No
    If yes, please remove
16. Pregnant or possibly pregnant ❑ Yes ❑ No
17. Able to lie still and flat ❑ Yes ❑ No
18. Claustrophobic ❑ Yes ❑ No
    ❑ Mild ❑ Moderate ❑ Severe
19. Sedation needed ❑ Yes ❑ No
    Type ______________
20. Need assistance changing or in wheelchair ❑ Yes ❑ No

MRI ❑ without contrast ❑ without & with contrast
(Please check one)
Body part

Reason for MRI & symptoms:

MRA ❑ without contrast ❑ without & with contrast
(Please check one)
Body part

Reason for MRA & symptoms: