



Questionnaire for MRI/MRA Exams

Name: _____ Age: _____ Wt: _____

Phone: _____ Test: _____ Date: _____

1. Have you had a previous MRI? If yes, when: _____ Yes or No
2. Do you have a pacemaker or defibrillator? Yes or No
3. Do you have any aneurysm clips from brain surgery? Yes or No
4. Do you have any kidney problems or kidney failure? Yes or No
5. Have you had any surgeries in the last 6 weeks? Yes or No
6. Do you have any metal in your body? Yes or No
7. Do you have any implants? Yes or No
 - A. Stents – if 8 weeks post-op and card they are OK
 - B. Valves – will need a card?
 - C. Ear
 - D. Coils
 - E. Stimulator
 - F. Penile
8. Do you have any device attached to your body (e.g. telemetry unit, insulin pump or tens unit)? Yes or No
9. Are you claustrophobic? Yes or No
10. Have you had any metal removed from your eyes? Yes or No
11. Do you have any allergies? Yes or No

If so, what? _____
12. Are you pregnant? Yes or No
13. Have you had a surgical operation of any kind? Yes or No

14. Do you wear any type of transdermal patch (e.g. nicotine, birth control, etc.) Yes or No
15. Do you have any personal history of cancer? Yes or No
16. Reason for exam: _____

Patient's signature: _____ Date: _____ Int: _____

TECHNOLOGIST USE ONLY

Exam: _____

Emergency Medication Available Yes or No

Time Out (Patient, Site, Position, Equipment verified) Yes or No

Procedure and Possible Side Effects Explained to Patient Yes or No

Contrast Volume/Type: _____

Injection Time: _____ Amount of Fluoroscopy _____

Patient Tolerated: _____

Technologist Signature: _____