

- Adventist Bolingbrook Adventist GlenOaks
 Adventist Hinsdale Adventist La Grange Memorial

Date: ___/___/___ Time: _____

PATIENT'S NAME:	WEIGHT:
SPECIFIC EXAM REQUESTED:	
REQUESTING PHYSICIAN:	

List any previous surgery with dates pertaining to your current problem.

For what reason or symptom is this test being ordered?

List any allergies.

The following items can interfere with MRI Imaging and may be hazardous to your safety. Please check every item.

- | | | | |
|------------------------------|-----------------------------|-------------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Cardiac Pacemaker If Yes NO MRI WILL BE PERFORMED. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Do you have a history of Kidney disease, Kidney surgery, Renal failure or are you on Kidney Dialysis? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Intracranial bypass graft clips |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Surgery within last 2 weeks. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Shunts, Brain or Spine |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Electrodes: Neurostimulator, middle ear prosthesis, biostimulator, etc. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Orbital Prosthesis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Hearing Aid |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Heart Valve Name & Model #: _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Orthopedic Devices: Pins, Wires, Rods, Plates, Screws, etc. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Any implanted pump i.e., insulin, pain medication, etc. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Artificial Limb |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Joint Prosthesis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Metal Fragments in Head, Eyes or elsewhere in body |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Orthodontics |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Dentures |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Have you ever had a previous reaction to MRI contrast dye? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Do you have a history of asthma? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Are you pregnant? Date of last period: _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know | Inpatient: Infusion Pump and/or Monitors . . . If Yes, must be disconnected prior to exam. |

If any "Yes" or "Don't Know" have been checked, then Magnetic Resource Imaging may be hazardous. The above information will be reviewed by the Radiologist prior to your examination for a determination.

— IMPORTANT —
If you ever had metal fragments in your eyes, or were required to wear safety goggles and did not always wear the goggles while working, you may have metal fragments in your eyes today and not be aware of them. This condition could very well lead to blindness doing the MRI exam. Orbital X-rays MAY show these fragments and MUST be obtained before the MRI scan. However, orbital X-rays MAY NOT detect all metallic foreign bodies. In that event, if you have an MRI scan, you do so at your own risk.

Before entering the scanning suite the patient must remove:
Hearing aids, all removable metal objects, watches, all glitter makeup, all eye makeup.

History is accurate to the best of my knowledge. Patient or Legal Representative: _____

Reviewed by: _____ RN (For Inpatient only) Tech: _____

MRI Patient Questionnaire

