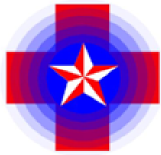
Patient Name:_________________________ Chart Number:________________________



# TRUE MEDICAL IMAGING
# MEDICAL QUESTIONNAIRE
# MRI CHECK LIST

**We will be placing you in a large OPEN magnet; you will hear a "knocking" which will persist while the test is being performed.**

**This checklist is for you safety. Some of these items might make it hazardous for you to enter a strong magnetic field. If you are unsure of an answer, please let the receptionist and/or technologist know and they will be happy to answer any questions you may have with this questionnaire.**

**Do you have the following?**

| Item | Yes | No |
|---|---|---|
| Brain Shunt | Yes___ | No___ |
| Neurostimulators | Yes___ | No___ |
| Hearing Aids | Yes___ | No___ |
| Ear Prosthesis (Cochlear Implant) | Yes___ | No___ |
| Aneurysm Clips for Brain Surgery | Yes___ | No___ |
| Cardiac pacemaker | Yes___ | No___ |
| Coronary Artery Clips | Yes___ | No___ |
| Heart Valve Replacement | Yes___ | No___ |
| Bypass Surgery | Yes___ | No___ |
| Implanted Defibrillator | Yes___ | No___ |
| Insulin Pump | Yes___ | No___ |
| Any Implanted Electronic Device | Yes___ | No___ |
| Worked as a Metal Worker | Yes___ | No___ |
| Worked as a Lock Smith | Yes___ | No___ |
| Worked as a Key Maker | Yes___ | No___ |
| Worked as a Welder | Yes___ | No___ |
| Had an Injury to either eye | Yes___ | No___ |
| Hair Extensions | Yes___ | No___ |
| Permanent eye lining/Tattooing | Yes___ | No___ |
| Joint Replacement | Yes___ | No___ |
| Fractured Bones Replacement | Yes___ | No___ |
| Metal Rod, Screws Pins or Nails | Yes___ | No___ |

If yes, explain:_______________________________________________________________________

_____________________________________________________________________________________

**Any personal history of:**

| Condition | Yes | No |
|---|---|---|
| Headaches | Yes___ | No___ |
| Dizziness | Yes___ | No___ |
| Seizure disorder | Yes___ | No___ |
| Stroke | Yes___ | No___ |
| Heart Disease | Yes___ | No___ |
| Asthma | Yes___ | No___ |
| Allergic Respiratory Disease | Yes___ | No___ |
| Chronic Obstructive Pulmonary Disease (COPD) | Yes___ | No___ |
| Diabetes | Yes___ | No___ |
| Liver Disease | Yes___ | No___ |
| Renal Failure | Yes___ | No___ |
| Kidney/Bladder disease | Yes___ | No___ |
| Prostate Problems | Yes___ | No___ |
| Hepatitis | Yes___ | No___ If yes, what type:_______________ |
| Multiple Myeloma | Yes___ | No___ |
| Blood disorder/Sickle Cell | Yes___ | No___ |
| HIV Positive | Yes___ | No___ |

Explain:_____________________________________________________________________________

Please sign below to confirm that you fully understand this questionnaire and that you are able to answer every question.

_________________________________ ___________________

Patient/Guardian signature Date