

AMERICAN WELLNESS & IMAGING
QUESTIONNAIRE

MRI SCREENING

Appt. Date _____ Time _____

Name _____ Phone 1 _____ Phone 2 _____

DOB _____ Height _____ Weight _____ (if over 350 lbs., we cannot do an MRI here)

Primary Care Physician _____ Ordering Physician _____

Date of Follow-Up Appt. w/ Physician _____

Insurance _____ Precert _____

Scan / Study _____ R/O _____

Appointment made by: _____ PT. _____ MD _____ INS CO. _____ Scheduler _____
Date _____

This questionnaire is designed to assist us in determining if it is safe for you to undergo an MRI. It is important that you answer all of the following questions to the best of your knowledge.

_____ Have you ever had an MRI on the body part we are scanning? If yes, when? _____ **Please bring your films?**

_____ Have you ever had surgery on the body part we are scanning? If yes, when? _____ (contrast may be indicated)

_____ Do you suffer from claustrophobia? (If yes, a mild sedative can be taken)

_____ Do you have a history of cancer, leukemia or lymphoma? (contrast may be indicated)

_____ Can you lie flat comfortably? (if you are in pain, we will need a medication order to be given on call for the

_____ Are you ambulatory? _____ MRI procedure)

_____ **For Women:** Is there any chance you may be pregnant, are pregnant or nursing?

MEDICAL DEVICES / METAL SCREENING: (if yes to the following questions, may not be able to have an MRI)

_____ Do you have a Cardiac Pacemaker, Internal Defibrillator or Implanted Heart Valves?

_____ Cerebral Aneurysm Clips?

_____ Metal Pins, Joints, or other Surgically Implanted Metal of any type?

_____ Have you had a war injury or gun shot wound? _____ Was the bullet removed?

_____ Have you ever been exposed to metal fragments that could be lodged in your eyes or body?

_____ Have you ever had metal removed from your eyes or any other part of your body? If yes, what part?

_____ Do you have any concealed body piercing? If yes, please remove prior to your exam.

_____ Do you have any type of electronic device (stimulator or pump) implanted in your body?

_____ **For Women:** Do you have an IUD?

PATIENT HISTORY:

_____ Have you ever had an adverse reaction to an IV contrast injection? If yes, describe _____

_____ Do you have a history of Renal (kidney) Disease?

_____ Do you have a history of Seizures?

_____ Do you have a history of Asthma?

_____ Do you have a history of Emphysema?

_____ Do you have Allergies? If yes, please describe _____

_____ Have you ever had chemotherapy or radiation therapy?

_____Do you have any other medical problems? If yes, please describe

I certify that I have read and understood the questions asked in this questionnaire and that the above responses are correct to the best of my knowledge.

Patient or Legal Representative Signature

Print Name and Authority (if legal representative)

Date

Physician / Technologist

Print Name and Title

Date

Technologist Notes:
