North Shore-LIJ Staten Island University Hospital
VERRAZANO

QUESTIONNAIRE for MRI

Name: _____ Date: _____

TO THE PATIENT: In order for us to provide your doctor with the most accurate diagnosis, it is most important that you, the patient provide us with the following necessary information. If you require assistance with this questionnaire, please do not hesitate to ask the receptionist or the technologist, as this is a very important part of your examination today.

1. Do you have any of the following devices?

If you are uncertain, please check "yes" and notify the technologist prior to entering MRI room.

Yes	No		
☐	☐	Heart Pacemaker	
☐	☐	Internal Defibrillator (AICD)	
☐	☐	Brain (aneurysm) clip	
☐	☐	Cochlear or stapes implant	
☐	☐	Neurostimulator	
☐	☐	Infusion / Insulin pump	
☐	☐	Sternal Wires / Stents	
☐	☐	Artificial Heart Valve	
☐	☐	Vascular (umbrella) filter for clots	
☐	☐	Metal splinters / fragments	
☐	☐	Shrapnel (gunshot injury)	
☐	☐	Metallic Shunt (spinal vent)	
☐	☐	Eye injury / prosthesis	
☐	☐	Metal joints, rods, plates	Medicated
☐	☐	Screws, nails, clips, pins	Skin Patch?
☐	☐	IUD (intrauterine device)	Yes__ no__
☐	☐	Dentures / partial	
☐	☐	Hearing aid	

Are you pregnant? ☐ Yes ☐ No

When was your last menstrual period? _____

2. In reference to your body part being scanned today by MRI:

A) Prior Exams of this body part

☐ MRI ☐ C.T. ☐ Myelogram ☐ X-ray

Findings _____

Date and location of exam _____

B) Describe prior surgery to region being scanned _____

C) Prior history of trauma to region being scanned?

☐ Yes ☐ No

D) Prior history of cancer of any location in body?

☐ Yes ☐ No Body Part _____

E) Prior radiation therapy to region being scanned today?

☐ Yes ☐ No Body Part _____

F) Describe symptoms _____

3. For MRI of Spine

Side of pain ☐ L ☐ R

4. For MRI of Head / Neck / Orbits

Which side ☐ L ☐ R

List symptoms _____

5. For MRI of Orthopedic Regions

Which side ☐ L ☐ R

List symptoms _____

6. For TMJ (temporo-mandibular joint) MRI only:

Which of these symptoms do you have?

L	R	
☐	☐	Pain
☐	☐	Click
☐	☐	Headache
☐	☐	Ear Ache
☐	☐	Neck Pain
☐	☐	Difficulty Opening
☐	☐	Difficulty Chewing

Describe prior surgery to region being scanned _____

Prior history of trauma to region being scanned? ☐ Yes ☐ No

Have you had or do you have an oral appliance or splint?

☐ Yes ☐ No If yes, please give dates: _____

HAVE YOU CHECKED AND UNDERSTOOD ALL APPROPRIATE BOXES?

Patient or Guardian Signature _____ Technologist _____