NWI NORTHWESTERN IMAGING

MRI HISTORY QUESTIONNAIRE

Patient Identification

Name:
DOB:
MRN:

Height: _____
Weight: _____

☐Yes ☐No Cardiac pacemaker/ Defibrillator
☐Yes ☐No Aneurysm clip(s)/ Aortic clips
☐Yes ☐No Carotid artery vascular clamp
☐Yes ☐No Neurostimulator
☐Yes ☐No Insulin or infusion pump
☐Yes ☐No Implanted drug infusion device
☐Yes ☐No Bone growth/fusion stimulator
☐Yes ☐No Cochlear, otologic or ear implant
☐Yes ☐No Any type of prosthesis (eye, penile, etc)
☐Yes ☐No Heart valve prosthesis
☐Yes ☐No Artificial limb or joint_____
☐Yes ☐No Electrodes (on body, head or brain)
☐Yes ☐No Intravascular stents, filters or coils

Implant Date: _____

☐Yes ☐No Shunt (spinal or intraventricular)
☐Yes ☐No Vascular access port and/or catheter
☐Yes ☐No Swan-Ganz catheter
☐Yes ☐No Any implant held in place by a magnet
☐Yes ☐No Transdermal delivery system (Nitro patch)
☐Yes ☐No IUD , diaphragm or pessary
☐Yes ☐No Tattooed makeup (eyeliner, lips, etc.)
☐Yes ☐No Body piercing(s)
☐Yes ☐No Metal or fragments, bullets, or shrapnel
☐Yes ☐No Internal pacing wires
☐Yes ☐No Metal or wire mesh implants
☐Yes ☐No Wire sutures or surgical staples
☐Yes ☐No If yes to previous question, is it a gastrointestinal Endo clip
☐Yes ☐No Harrington rods(spine)
☐Yes ☐No Metal rods in bones
☐Yes ☐No Bone/joint in, screw, nail, wire, plate
☐Yes ☐No Tissue Expander (breast)
☐Yes ☐No Hearing aid ***(Remove before MRI)***
☐Yes ☐No Dentures ***(Remove before MRI)***

Other, please explain:_____

☐Yes ☐No If indicated that patient has a Pacemaker, is it MRI safe

Please indicate the make and model of the MRI Safe Pacemaker:
Make:_____Model:_____

Please list all surgeries or invasive procedures (Include Date):
_____
_____
_____
_____

☐Yes ☐No If the patient has had recent surgery, and a bandage is present, does the wound bandage contain a silver coating for antimicrobial purposes?

Have you ever had metal stuck in your eyes from grinding, drilling, welding?
_____

Does the patient have a temperature sensing Foley Catheter?
_____

Have you had any previous imaging procedures of the affected area?
_____

If yes, when and where were the tests performed?
_____

☐Yes ☐No Does the patient have any metal lined or copper clothing (Socks, undergarments, leggings)
(These should be removed prior to a MRI scan due to the metallic lining.)
☐Yes ☐No Diabetic
☐Yes ☐No Claustrophobic
☐Yes ☐No Females: Pregnant or breast feeding
Date of last menstrual period:_____

_____ _____ _____
Patient Signature Date Time

Form completed by: ☐Patient ☐Physician ☐Other _____
Name & relationship to patient

_____ _____ _____
Technologist Signature Date Time