



MRI QUESTIONNAIRE

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

|          |        |        |                |
|----------|--------|--------|----------------|
|          | Last   | First  | Middle Initial |
| Sex: M F | _____  | _____  | _____          |
|          | Weight | Height | Age            |
|          | _____  | _____  | _____          |

Referring Physician: \_\_\_\_\_

If Female, Date of Last Menstrual Period: \_\_\_\_\_

Type of Study Ordered: \_\_\_\_\_

Do you have any history of cancer? YES NO If YES, what type? \_\_\_\_\_

Please indicate any previous exams relating to this injury or illness (Circle all that apply)

MRI                      CAT Scans                      X-Rays                      Lab Test

Please describe the symptoms of your injury or illness: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please circle YES or NO for each statement below:

|                               |        |   |        |
|-------------------------------|--------|---|--------|
| I am claustrophobic           | YES NO | I have metallic implants                      | YES NO |
| I get very nervous at times   | YES NO | I use a hearing aid                           | YES NO |
| I have ear implants           | YES NO | I have dentures                               | YES NO |
| I have had head surgery       | YES NO | I have drug allergies                         | YES NO |
| I have had other surgeries    | YES NO | I have had liver disease                      | YES NO |
| I have a pacemaker            | YES NO | I have a mechanical heart valve               | YES NO |
| I have had metal in my eyes   | YES NO | I have carotid clamps                         | YES NO |
| I have a prosthesis           | YES NO | I have intravascular stints, coils or filters | YES NO |
| I am or may be pregnant       | YES NO | I have shrapnel in or near my eyes or         | YES NO |
| I am currently breast feeding | YES NO | Spine (BBs in Body)                           |        |
| I have sickle cell anemia     | YES NO | I have an Insulin Pump Neurostimulator        | YES NO |
| I have blood disorders        | YES NO | (Tens Unit)                                   |        |
| I had a previous CAT Scan     | YES NO | I have a Holter Monitor or Defibrillator      | YES NO |
| I had a previous MRI          | YES NO | I have a tissue expander w/magnetic port      | YES NO |
| I have intracranial clamps    | YES NO |   |        |

(Continued on reverse side)

If you answered YES to any of the previous questions, please explain in detail.

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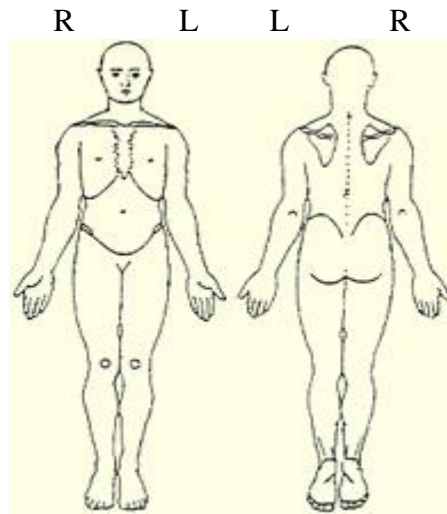
Please describe any other medical history information you think we should know about.

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Draw on these figurines where your pain symptoms are located  
Circle symptoms

- |           |              |
|-----------|--------------|
| Pain      | Speech       |
| Numbness  | Confusion    |
| Tingling  | Seizures     |
| Burning   | Hearing Loss |
| Headaches | Balance      |
| Weakness  | Walking      |
| Visual    | Memory       |



I have answered these questions to the best of my knowledge and understand the information presented to me.

Patient/Parent/ Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Technologist/Witness Signature: \_\_\_\_\_

| TECHNOLOGIST USE ONLY:    |                                    |                        |                |               |
|---------------------------|------------------------------------|------------------------|----------------|---------------|
| Amount                    | CC of Magnevist with a             | GA & needle type       | Time           | Site Location |
| _____                     | _____                              | _____                  | _____          | _____         |
| By: _____                 | Lot: _____                         | Expiration Date: _____ | # of Punctures |               |
| Contrast Reaction: YES NO | Physician Covering Contrast: _____ |                        |                |               |
| Comments: _____           |                                    |                        |                |               |



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### Patient Intake Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female  
(circle one)

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
(Home) (Cell)

Email: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

Insurance/Responsible Party: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
(Name) (Relationship to Patient)

Phone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
(Home) (Cell)

Address: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Please list below any additional Doctors you would like your report sent to

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_