

Open MRI of Williamsport Patient Questionnaire

Please list the reason for the MRI and details of your symptoms _____

Duration of symptoms _____ Date of onset of symptoms or injury _____

Are your symptoms the result of an injury? _____ If so, please describe _____

Work related injury? _____ Or MVA? _____

Please list all prior surgeries _____

Have you ever experienced any problem related to a previous MRI examination? _____

Have you ever had a reaction to MRI contrast? _____ If so, please describe _____

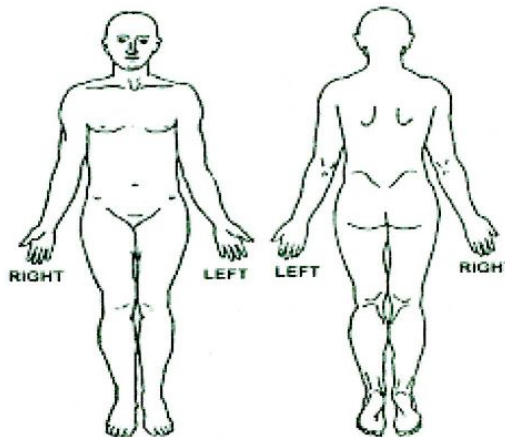
Have you had any prior related diagnostic examinations? _____

If so, please list:	Body Part	Date	Facility
MRI	_____	____/____/____	_____
CT/CAT Scan	_____	____/____/____	_____
X-Ray	_____	____/____/____	_____
Ultrasound	_____	____/____/____	_____
Nuclear Medicine	_____	____/____/____	_____

Please indicate if you have any of the following:

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker, wires, or defibrillator |
| <input type="checkbox"/> | <input type="checkbox"/> | Brain aneurysm clips |
| <input type="checkbox"/> | <input type="checkbox"/> | Any vascular stents, filters, coils or artificial heart valves |
| <input type="checkbox"/> | <input type="checkbox"/> | Implanted drug infusion pump or insulin pump |
| <input type="checkbox"/> | <input type="checkbox"/> | Implanted neurostimulator, spinal cord or bone stimulator |
| <input type="checkbox"/> | <input type="checkbox"/> | Work with metal or had metal removed from your eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing Aid |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye implant, eyelid spring, retinal tack, or artificial eye |
| <input type="checkbox"/> | <input type="checkbox"/> | Metal shrapnel, bullet, BBs, or pellets |
| <input type="checkbox"/> | <input type="checkbox"/> | Any metallic fragment or foreign body |
| <input type="checkbox"/> | <input type="checkbox"/> | Electronic or magnetically-activated implant or device |
| <input type="checkbox"/> | <input type="checkbox"/> | Cochlear or other ear implant |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant or breast feeding? |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint replacement or orthopedic hardware |
| <input type="checkbox"/> | <input type="checkbox"/> | IUD, diaphragm, or pessary |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of prosthesis or implant _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Medication Patch |
| <input type="checkbox"/> | <input type="checkbox"/> | Magnetic dental implant |
| <input type="checkbox"/> | <input type="checkbox"/> | Body piercing jewelry |
| <input type="checkbox"/> | <input type="checkbox"/> | Tattoos or permanent makeup |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Cancer? If so, what type? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Any Kidney problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease |

Please shade in the areas where you are having your pain or symptoms



I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form and the MRI procedure that I am about to undergo.

Patient's Name: _____ Date of Birth ____/____/____ Weight _____

Signature of Person Completing Form: _____ Today's Date ____/____/____

Form Completed By: Patient Relative Nurse _____

Form Information Reviewed By: _____ Front Desk _____ Technologist