Deaconess Health System

MRI and MRA SAFETY QUESTIONNAIRE

☐ Deaconess Hospital Radiology ☐ Deaconess Gateway Hospital Radiology ☐ Midwest Radiology

Patient's Name: _____ **Patient's Date of Birth:** _____

The Doctor who sent you to us for this exam: _____ **Patient's Height:** _____

Patient's Weight: _____

Date and the time of your MRI appointment:_____

The MRI Scan Room contains a VERY strong magnet. For your safety, we must ask some very important questions before allowing you into the scan room. Please answer these questions carefully and let us know if you have any questions or concerns.

Today's MRI exam will be on your:

Brain and/or Head_____

Back or Spine (specify the area):

- ☐ Cervical spine (neck/upper back)
- ☐ Thoracic spine (middle back)
- ☐ Lumbar spine (low back)

Extremity (right knee, left shoulder, etc.)

_____

Abdomen_____

Other_____

Have you ever had an MRI or an MRA before?

IF YES: When? _____

Where?_____

Have you had a CT scan related to today's MRI?

IF YES: When?_____

Where?_____

If today's MRI is on your spine (neck or back), please answer this:

Have you ever had surgery on your spine?☐Yes☐No

If yes, please specify what type of surgery:

Neck/Upper Back_____Mid Back_____Low Back_____

Please place a check in the yes or no box for each question below.

	Yes	No		Yes	No
Have you ever had surgery on your **brain**?			**Dentures or Partial Plates*?**		
Anything **Implanted** in your brain?			*Are they held in by a **Magnet?**		
Aneurysm clips in your Brain or Abdomen?			Any **Hearing Aids** today?		
Have you ever had surgery on your **heart**?			Any metal in your hair?		
Are there any **stents**, **valves** or **shunts** in your body?			Any **Piercings?**		
Ever had a **pacemaker or defibrillator** in your body / brain?			Are you **Pregnant?**		
Have you ever had **surgery** on your inner **ear**?			Are you **Breastfeeding?**		
Are there any medical **devices** implanted in either **ear**?			Are you wearing any **Medication Patches** (for pain, smoking, etc.)**?**		
Any **pain pumps** or **insulin pumps** in your body?			Are you **Claustrophobic?**		
Any **stimulators, coils, filters or ports** in your body?			Have you had any **Surgery** in past 8 weeks?		
Have you ever been diagnosed with **high blood pressure?**			Have you had a **Colonoscopy** in the past 2 years?		
Have you ever been diagnosed with **Diabetes?**			-Were any **polyps** removed?		
Do you have **liver disease** or a **liver transplant**?			Have you ever had **cancer?**		
Do you have **kidney disease** or ever had **kidney failure**?			Would you like your results to be sent to any other doctors?		
Are you currently on **kidney dialysis**?			Who?		
Is there anything implanted inside your body? *Example may include: joint, pin, screw, plate, rod, cage, wire, lens implant, clip,penile implant, IUD, staple, mesh, bullet, BB, shrapnel*			Do you have any additional comments/concerns regarding your exam today:		
Have you ever had **metal in your eyes** from welding,grinding, sheet metal work or sharpening lawn mower blades?					

_____ _____

Patient or Representative **Technologist**

_____ _____

Date/Time **Date/Time**