MUNSON HEALTHCARE

FORM #11925 (03/18)

# MRI SCHEDULING QUESTIONNAIRE

Date: _____

Patient name: _____

Date of birth: Insurance: Current weight: _____

1. **Are you allergic to MRI contrast?** ☐ Yes ☐ No
   *If yes,* what are your symptoms? _____
2. Do you have a Pacemaker? ☐ Yes ☐ No
3. Do you have any implanted devices (i.e., stents, pain pumps, filters, etc.)? ☐ Yes ☐ No
   *We may need make and model*
4. Do you have a history of **cancer/tumor** on the are to be scanned? ☐ Yes ☐ No
   *If yes,* what kind? _____
   Date of diagnosis: _____ (Month) /_____ (Year)
5. Have you had a **prior surgery** on the area to be scanned? ☐ Yes ☐ No
   *If yes,* what type?_____
6. Have you had any **previous radiology studies** on the area to be scanned? ☐ Yes ☐ No
   *If yes,* what exams? (i.e., ultrasound, MRI, X-ray, etc.)

   _____

   Where were the studies done?_____
7. Do you have any metal in your body? (i.e., fragments in the eye, gunshot wound, etc.) ☐ Yes ☐ No
8. Have you had surgery to repair a brain aneurysm? ☐ Yes ☐ No
9. Are you Claustrophobic? ☐ Yes ☐ No