



# MAIN STREET RADIOLOGY

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136-25 37th Ave.  
Flushing, New York 11354

## MRI QUESTIONNAIRE

**NAME (PLEASE PRINT)** \_\_\_\_\_ **DATE** \_\_\_\_\_

<b>1. DO YOU HAVE A PACEMAKER OR ANY TYPE OF CARDIAC DEVICE?</b>	<b>YES</b>	<b>NO</b>
<b>2. HAVE YOU HAD ANY BRAIN SURGERY?</b>	<b>YES</b>	<b>NO</b>
<b>3. HAVE YOU EVER HAD ANY METALLIC FOREIGN OBJECTS IN YOUR EYE?</b>	<b>YES</b>	<b>NO</b>
<b>4. HAVE YOU EVER WORKED WITH SHEET METAL OR ANY METAL?</b>	<b>YES</b>	<b>NO</b>
<b>5. DO YOU HAVE A COCHLEAR IMPLANT OR NERVE STIMULATOR?</b>	<b>YES</b>	<b>NO</b>
<b>6. ARE YOU ON KIDNEY DIALYSIS?</b>	<b>YES</b>	<b>NO</b>

7. DO YOU HAVE ANY KIDNEY DISEASE OR CONDITION? YES NO

8. DO YOU HAVE DIABETES? YES NO

9. HAVE YOU HAD ANY OTHER SURGERY? YES NO  
IF SO, WHAT KIND? \_\_\_\_\_ DATES \_\_\_\_\_

10. DO YOU HAVE SHRAPNEL FROM A GUNSHOT WOUND? YES NO

11. ARE YOU CLAUSTROPHOBIC? YES NO

12. ARE YOU PREGNANT? YES NO

13. ARE YOU BREAST-FEEDING? YES NO

14. DO YOU HAVE AN IUD/DIAPHRAGM? INSULIN PUMP? YES NO

15. ARE YOU WEARING A TRANSDERMAL PATCH (EX: NICODERM, FETANYL, NITRO)? YES NO

IF YES, WHAT KIND? \_\_\_\_\_

16. WHAT IS YOUR APPROXIMATE WEIGHT? \_\_\_\_\_ HEIGHT? \_\_\_\_\_

17. ARE YOU HAVING ANY PAIN? YES NO IF YES, WHERE? \_\_\_\_\_

18. ARE YOU ALLERGIC TO ANY MEDICATION? YES NO IF YES, PLEASE LIST \_\_\_\_\_

19. WHY ARE YOU HAVING THIS MRI? \_\_\_\_\_

SYMPTOMS? LEFT OR RIGHT? \_\_\_\_\_

20. WHEN DID YOUR SYMPTOMS BEGIN? \_\_\_\_\_

21. DO YOU HAVE A HISTORY OF CANCER? \_\_\_\_\_

IF SO, WHAT TREATMENTS HAVE YOU HAD? \_\_\_\_\_

22. HAVE YOU HAD ANY PRIOR PROSTATE BIOPSY? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, WHEN ? \_\_\_\_\_

23. HAVE YOU HAD A PREVIOUS MRI / CT / XRAY / NUCLEAR MEDICINE STUDY / PET SCAN / ULTRASOUND?

IF SO, WHERE? \_\_\_\_\_ WHICH PART OF YOUR BODY? \_\_\_\_\_

**TO ALL OF OUR PATIENTS:** It is important to know if there are any metal fragments, pieces, bits, clips, devices or metal of any kind in your body. The presence of metallic items in the vital area(s) of your body may hinder the examination. You must inform us of any such possibility prior to the MRI examination.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_