RADIOLOGY ASSOCIATES OF RIDGEWOOD, P.A.

MRI/MRA PATIENT QUESTIONNAIRE

Name _____ **Date** _____

Type of MRI/MRA (Body Part) _____ **Age** _____ **DOB** _____

Weight _____ **lbs** **Height** _____

Do you have:	**Yes**	**No**
Cerebral Aneurysm Clips	❑	❑
Abdominal Aneurysm Clips / Filters	❑	❑
Pacemaker	❑	❑
Defibrillator	❑	❑
Tissue Expander	❑	❑

If you have these, you may not be able to have an MRI.

Do you have:	**Yes**	**No**
Heart Recorder/Loop Recorder	❑	❑
Any Pump	❑	❑
Shrapnel	❑	❑
Stents	❑	❑
Penile Implant	❑	❑
Any Metal Implant	❑	❑
Heart Valve	❑	❑
Neuro Stimulator	❑	❑
Hearing Aid	❑	❑
Cochlear Implant (ear implant)	❑	❑
IUD	❑	❑
Glucose Monitor	❑	❑
Insulin Pump	❑	❑
Dental / Braces	❑	❑

Personal Medical History:	**Yes**	**No**
Diabetes	❑	❑
Kidney Failure / Disease	❑	❑
Liver Disease / Hepatitis	❑	❑
Sepsis	❑	❑
Heart Disease	❑	❑
High Blood Pressure	❑	❑
Vascular Disease	❑	❑
Stroke	❑	❑
Seizures	❑	❑
Neurological Disorder	❑	❑
Insulinoma	❑	❑
Cancer Type: _____	❑	❑
Radiation Therapy	❑	❑
Chemo Therapy	❑	❑

1. Have you ever been a metal worker, machinist or cut/ground metal? ❑ Yes ❑ No
2. Is there any possibility you are pregnant? *(females between 12-52)* ❑ Yes ❑ No ❑ Unsure
   Last menstrual period: _____
   Signature _____
3. Are you breast feeding? ❑ Yes ❑ No
4. Do you have a transdermal patch (ie: nicotine or pain patch) on your body today? ❑ Yes ❑ No

List any allergies you have: _____

_____

List any medications you are presently taking:

_____

_____

_____

List any surgery you have had: _____

_____

Please describe your present symptoms:

_____

_____

_____

_____

_____

FOR OFFICE USE ONLY: Creatinine _____
Normal Range (0.6 - 1.3 mg/dl)
Acceptable Range (<2.0 mg/dl)

GFR _____
Normal Range (>60)
Acceptable Range (>30)

Injection:
Site: _____
Signature: _____

Gadavist: _____ cc Glucagon 0.5mg IV: _____
Eovist: _____ cc
Lot: _____
Exp: _____

Rx and history reviewed by: _____

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