DENVILLE DIAGNOSTICS 973.586.1212 | RADIOLOGY CENTER OF FAIR LAWN 973.238.0700 | STAR MRI OF WAYNE 201.475.1300

IMAGECARE CENTERS

1.2T Open MRI · 1.5T Extremity MRI · 1.5T Short/Wide Bore MRI · MR/CT Angiography · Arthrograms
CT Scan · Ultrasound · X-Ray · 3D Mammography · Bone Density · Dental Scan

MRI QUESTIONAIRE

Name: _____ DOB:_____ Date:_____

Type of MRI/MRA (body part):_____

Referring Doctor:_____ Weight:_____ Height:_____

Have you ever been a metal worker, machinist or cut or grind any metal? **YES NO**

If yes, did you wear protective eye covering? **YES NO**

Have you ever had a penetrating eye injury? **YES NO**

Is there any possibility that you are pregnant? **YES NO**

Last Period:_____

Are you breastfeeding? **YES NO**

Do you wear a transdermal patch **YES NO**

Are you wearing magnetic gel-nail polish? **YES NO**

List any surgery you have had: _____

_____

_____

Please describe your present symptoms:_____

_____

_____

Please list other diagnostic tests relating to this problem:_____

_____

Is this due to an auto accident or workers compensation claim? **Yes No**

Do you have:

Pacemaker	**YES**	**NO**	Date Implanted_____
Abdominal Aneurysm	**YES**	**NO**	Date Implanted_____
Cerebral Aneurysm Clips	**YES**	**NO**	Date Implanted_____
Defibrillator	**YES**	**NO**	Date Implanted_____
Tissue Expander	**YES**	**NO**	Date Implanted_____
IUD	**YES**	**NO**	Date Implanted_____
Shrapnel (bullets)	**YES**	**NO**	Date Implanted_____
Stents	**YES**	**NO**	Date Implanted_____
Any Metal Implant	**YES**	**NO**	Date Implanted_____
Heart Valve	**YES**	**NO**	Date Implanted_____
Neuro Stimulator	**YES**	**NO**	Date Implanted_____
Hearing Aid	**YES**	**NO**	Date Implanted_____
Cochlear Ear Implant	**YES**	**NO**	Date Implanted_____
Shunt	**YES**	**NO**	Date Implanted_____
Portacath	**YES**	**NO**	Date Implanted_____
Any other metals	**YES**	**NO**	Date Implanted_____
Greenfield Filter (IVC)	**YES**	**NO**	Date Implanted_____
Renal Failure/Disease	**YES**	**NO**	

Patient Signature:_____ Date:_____