MR#: ☐☐☐☐☐☐☐☐

Name of Patient:

Date of Birth:

Place Label Here

UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER
SACRAMENTO, CALIFORNIA

PATIENT QUESTIONNAIRE (MRI)

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant device or object. Consult the MRI Technologist or Radiologist BEFORE. **The MR system magnet is ALWAYS on.**

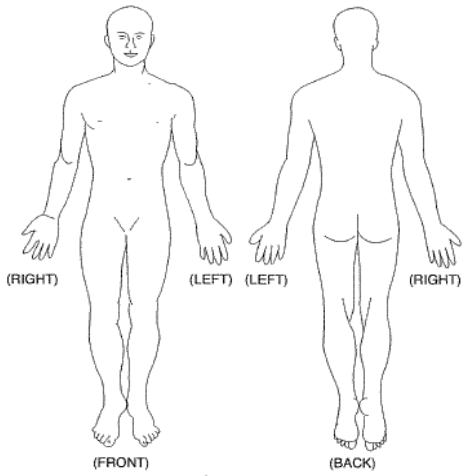
Name:_____ Medical Record Number:_____

Patient Weight:_____ DOB:_____ Date:_____

PATIENT QUESTIONNAIRE PRIOR TO MRI EXAMINATION

1.	❒ Yes	❒ No	Do you have or have you ever had a pacemaker or implanted defibrillator? MR exams **cannot** be performed on patients with cardiac pacemaker and/or defibrillators. If answered **Yes**, the exam **cannot** be performed
2.	❒ Yes	❒ No	Are you wearing a hearing aid?
3.	❒ Yes	❒ No	Do you have implanted electronic devices, cochlear implants, spinal column stimulator, infusion pumps, other implants? _____
4.	❒ Yes	❒ No	Have you ever had metal fragments or other foreign bodies in your eye?

5. Do you have any of the following in your body:
   - ❒ Yes ❒ No Aneurysm clips?
   - ❒ Yes ❒ No Heart valve prosthesis, vascular stent, or coil?
   - ❒ Yes ❒ No Swan Ganz Catheter?
   - ❒ Yes ❒ No IUD?
   - ❒ Yes ❒ No Penile implant?
   - ❒ Yes ❒ No Inferior Vena Cava Filter?
   - ❒ Yes ❒ No Any other type of prosthesis?



6. ❒ Yes ❒ No Is there any chance that you may be pregnant?
7. ❒ Yes ❒ No Are you now wearing ANY transdermal medicinal patches?
8. ❒ Yes ❒ No Have you had ANY upper G.I. study in the last two weeks?
9. ❒ Yes ❒ No Do you have any kidney disease?
10. ❒ Yes ❒ No Have you ever had any kidney surgery?
11. ❒ Yes ❒ No Have you had a kidney transplant?
12. ❒ Yes ❒ No Are you on dialysis?
13. ❒ Yes ❒ No Have you ever had a reaction to MRI contrast media?
14. ❒ Yes ❒ No Do you have a history of gunshot wound(s)?
15. ❒ Yes ❒ No Do you have any removable dentures or dental work?
16. ❒ Yes ❒ No Have you removed all body piercing jewelry; if any?
17. ❒ Yes ❒ No Do you have other metallic objects in or on your body?
    Specify:_____

If any of the above is "Yes" it may prevent MRI performance. Please contact MRI at 734-7959.

Reason for MRI and/or Symptoms:_____

Region being imaged: _____

Where is pain? ❒ Right ❒ Left ❒ Leg ❒ Arm ❒ Back Mark location of pain on diagram above.

How long have you had pain? Days: _____ Weeks: _____ Months: _____

Have you had any previous surgeries in the same area we are scanning today? ❒ Yes ❒ No

What was the surgery, and when was the surgery performed? _____

_____ ❒ Yes

Do you have any metal skin staples in place following recent surgery?	❒ Yes	❒ No
Have you had any previous imaging to the area being scanned today?	❒ Yes	❒ No

Signature of person completing form: _____