

SOFT TISSUE NECK/FACE EVALUATION

Last Name: _____	First: _____	Date: _____
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THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY

1. Have you had an MRI or CT scan of this body part previously? Yes No
2. If so, where and when?

2. What does your doctor think may be causing your problem? _____

3. Describe your symptoms:

4. Does anything make the symptoms better or worse?
Describe: _____

5. Any biopsies/surgery/arthroscopy on the area being scanned today? Yes No
Date of surgery? _____
What was done in surgery? _____

Results of
surgery: _____

7. Have you ever injured your face/neck? Yes No When? _____
What happened? _____

6. Are you currently taking any medications? Yes No List medications: _____

7. Do you have any other medical conditions/allergies? Yes No
Conditions: _____

8. Have you ever had cancer? Yes No If yes, what type? _____
Have you undergone chemotherapy, radiation therapy or surgery for cancer? Yes No
If yes, what type of cancer treatment have you had? _____

Dates of cancer treatments: _____

Please fill out back of this form





MRI SAFETY SCREENING QUESTIONNAIRE

Weight _____

Please provide a "yes" or "no" answer for every item

YES NO

- Heart pacemaker or implanted cardioverter defibrillator (ICD)
- Aneurysm clip/coil Date of implant: _____
- Internal electrodes or wires (pacing wires, DBS or VNS wires)
- Eye injury from a metal object (metal shavings, metal slivers)
- Artificial eye and/or eyelid spring
- Electronic implant/device or magnetically activated implant/device
- Neurostimulator/spinal cord stimulator/bone growth stimulator/deep brain
- Implanted drug pump (chemotherapy, pain medicine) External drug pump
- Metallic stent If yes, what kind _____ Date of Implant: _____
- Cochlear implant, middle ear implant
- Artificial heart valve, coil, filter If yes, then list _____
- Prosthesis of any kind (eye, ear, penile, limb) If yes, then list _____
- Shunt programmable/adjustable shunt or a non-programmable shunt
- Injured by a metal object (shrapnel, bullet, BB)
- Medication patch (nitroglycerin, nicotine, contraceptive, estrogen)
- Breast tissue expander
- Surgical clips, staples or mesh implants
- Implanted post-surgical hardware (pins, rods, screws, plates, wires)
- False teeth/dentures, partial plates, removable dental work, braces, retainer
- Body piercing jewelry, tattoos, permanent makeup
- Hearing aid(s) *Remove prior to entering MRI room*
- Other Implant If yes, then list _____

For patient getting contrast: Do you have a history of:

- | | | | | | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy in last 30 days | <input type="checkbox"/> | <input type="checkbox"/> | Allergic to MRI contrast |
| <input type="checkbox"/> | <input type="checkbox"/> | <i>Female patients only:</i> Are you pregnant or breast feeding? | | | |

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

PATIENT SIGNATURE	DATE
PERSON COMPLETEING THE FORM/RELATIONSHIP TO PATIENT	TECHNOLOGIST INITIALS:

Copy of report to any other physicians: _____