



**OPEN MRI CENTER**  
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**MRI QUESTIONNAIRE**

**Date:** \_\_\_\_\_

**Patient's Name:** \_\_\_\_\_

**Account #:** \_\_\_\_\_

**Body part or area to be scanned today (indicate RIGHT or LEFT if necessary):**

\_\_\_\_\_

**Have you had a prior scan of this same body part or area? Yes No**  
**If yes, where and when?**

\_\_\_\_\_

**For JOINT MRI exams: Recent injury? Yes No**

**Describe nature of any injury, pain or other symptoms, such as clicking, locking, etc.**

\_\_\_\_\_

\_\_\_\_\_

**For SPINE MRI Exams: Recent injury? Yes No**

**Describe nature of any injury, pain or other symptoms, especially symptoms in arms or legs and on which side:**

\_\_\_\_\_

\_\_\_\_\_

**For BRAIN MRI exams:**

**Describe symptoms in detail, including which side of the head, face or body if applicable and when they started:**

\_\_\_\_\_

\_\_\_\_\_

**You should not undergo MRI if you have any of the following. Circle Yes or No**

<b>Cardiac Pacemaker</b>	<b>Yes</b>	<b>No</b>	<b>Aneurysm Clips</b>	<b>Yes</b>	<b>No</b>
<b>Heart Valve</b>	<b>Yes</b>	<b>No</b>	<b>Heart Surgery</b>	<b>Yes</b>	<b>No</b>
<b>Ear Implant</b>	<b>Yes</b>	<b>No</b>	<b>Penile Implant</b>	<b>Yes</b>	<b>No</b>
<b>Pregnancy</b>	<b>Yes</b>	<b>No</b>	<b>Any Metal in Body</b>	<b>Yes</b>	<b>No</b>
<b>Nitroglycerin Patch</b>	<b>Yes</b>	<b>No</b>			

**Have you done welding or sheet metal work? Yes No**

**Have you ever had metal removed from your eyes? Yes No**

\_\_\_\_\_  
**Signature of patient (18+) or guardian**