THE ORTHOPAEDIC INSTITUTE OF SOUTHERN ILLINOIS

MRI QUESTIONNAIRE

NAME: _____ AGE: _____D.O.B.: _____ M/F

HEIGHT: _____WEIGHT: _____

Describe your symptoms and how long they have been present:_____
_____
_____

Did you have an injury? If so, please describe:_____
_____

CIRCLE AFFECTED BODY PART: RIGHT / LEFT
KNEE SHOULDER WRIST ANKLE ELBOW HAND FOOT ARM LEG OTHER_____

CIRCLE ANY THAT APPLY:
PRIOR SURGERY
INJURY
PAIN
SWELLING
JOINT LOCKS
JOINT GIVES WAY

PLEASE CHECK **YES** OR **NO** TO THE FOLLOWING QUESTIONS:
DO YOU NOW OR HAVE YOU EVER HAD:

1. A heart pacemaker? Yes__No__
2. Heart Valve? Yes__No__
3. Brain Surgery? Yes__No__
4. Aneurysm clips, vascular clips, intravascular filter, coil or stent? Yes__No__
5. Eye surgery or implant? Yes__No__
6. Ear surgery or implant? Yes__No__
7. Any type of implanted devices such as electrodes, TENS unit, neurostimulator, heart valve, mechanical or magnetic device? Yes__No__
8. Any metallic foreign body (shrapnel, bullet, bb pellet, etc…) Yes__No__
9. Have you ever had an eye injury caused by metal? Yes__No__
10. Have you ever been a metal worker, grinder, welder, machinist, etc… as a hobby or as a professional? Yes__No__
11. Are you wearing a hearing aid or dentures? Yes__No__
12. Have you ever been diagnosed as having cancer? Yes__No__
    if so, when and what type? _____
13. Do you have other medical problems that may be pertinent to and MRI exam? Yes__No__
    if so, please list them: _____

Female Patients Only:
Are you pregnant, or do you suspect that you could be pregnant? Yes__No__

DATE:_____ SIGNATURE OF PATIENT: _____