RYE RADIOLOGY
Dedication • Expertise • Technology

30 Rye Ridge Plaza
Rye Brook, NY 10573
914-253-9200 or 1-877-RYE-RADS

MRI QUESTIONNAIRE FORM

Please fill out the form below and bring to your first visit

PATIENT NAME: ____________________ AGE: _______ DATE: _______
OCCUPATION: ______________________ REF. Dr.: _______________________

If you do not understand any of the following questions, please speak to the doctor or the technologist to help you complete the form.

A. What symptoms have you been having that caused your doctor to order the MRI?
____
____

B. Have you had x-rays or other examinations of the parts of your body that we are going to examine today? Yes____ No____ If yes, please list: ____________________________

C. Have you ever had any operations? Yes____ No____ If so, please list the types, where and when? _________________________

D. Do you have allergies? Yes____ No____ If yes, please list: _______________________

E. Do you have any anemia or abnormalities of the red blood cells (sickle cell anemia, hereditary spherocytic anemia, etc.)? Yes____ No____ If yes, please list: _____________________

It is important for us to know if any of the following materials may be present within your body before we bring you into the MRI examining room. Please answer the following questions.

Do you have a history of any of the following?	**YES**	**NO**
1. Do you have a pacemaker? YOU MUST INFORM THE STAFF	____	____
2. Do you have a glucose pump or glucose monitor?	____	____
3. Do you have any kidney disease?	____	____
4. Do you have a prosthetic heart valve?	____	____
5. Have you had any heart surgery?	____	____
6. Do you have implanted neurostimulators?	____	____
7. Any eye surgery besides cataract removal?	____	____
8. Have you had any brain surgery?	____	____
9. Implant? Do you have an implant card?	____	____
10. Do you have brain aneurysm clips?	____	____
11. Have you had a shrapnel injury?	____	____
12. Metal working experience?	____	____
13. Do you have any joint replacements?	____	____
14. Any metal in your body besides fillings?	____	____
15. Cosmetic tattooing of your eyelids?	____	____
16. **FEMALE PATIENTS**		
i. Are you pregnant?	____	____
ii. Nursing?	____	____

I have received the Medication Guide for Prohance. ___ (Initial IF APPLICABLE)

PATIENT'S SIGNATURE: ______________________________ TECHNOLOGIST'S SIGNATURE: __________________________