

UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS Department of Radiology Patient Questionnaire for MRI	BIRTHDATE NAME REG NO
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Patient's Height: _____ ft/cm _____ in. **Weight:** _____ kg/lb **Travel:** Wheelchair Stretcher SWAT

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING: **NO** **YES** **UNKNOWN**

1. Have you experienced any problem(s) related to a previous MR Procedure? If yes, describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had an allergic reaction to MRI contrast (Gadolinium)? Have you ever received steroid prep for gadolinium enhanced MRI at UMH or another institution?"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a life threatening allergic reaction to anything?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you pregnant or nursing (lactating)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have sickle cell anemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had kidney failure; kidney or bladder surgery; kidney transplant or have you been told you have poor kidney function? If yes: Creatinine _____ Bun _____ GFR _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have any history of cancer? Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have breathing difficulties or are you on Oxygen or a Ventilator? Describe: _____ Any previous surgery? If YES, indicate Date & Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you had a capsule endoscopy in the last 30 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you had any of the following surgeries/implants/devices, If YES indicate Date and type: _____			
Cardiac pacemaker, pacemaker or pacemaker wires	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any type of heart surgery, artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain aneurysm surgery or other aneurysm clips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cochlear, otologic, middle ear or other ear implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataract surgery/eye lens implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mechanical/electrical/stimulators/pumps or devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurostimulator/deep brain stimulator, vagal nerve stimulator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial limb or prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metal tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever sought medical attention for a piece of metal in your eye?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have difficulty standing without assistance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Are you claustrophobic? If YES, do you need a sedative? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Is the patient physically/mentally impaired or unresponsive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have uncontrollable shaking or breathing problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you have trouble lying on your back for more than one hour?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you have any of the following items inside of or on your body? Please check:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/> Bullets/BB's/pellets/shrapnel	<input type="checkbox"/> Shunts/stents/coils/filters	<input type="checkbox"/> Dental implants	<input type="checkbox"/> Bone/Neuro stimulator
<input type="checkbox"/> Tattoo/permanent make-up	<input type="checkbox"/> Programmable shunts	<input type="checkbox"/> IUD/Prosthesis (penile, etc)	<input type="checkbox"/> Vascular access port/catheter
<input type="checkbox"/> Metal fragments	<input type="checkbox"/> EKG patches	<input type="checkbox"/> Breast implants	<input type="checkbox"/> Foley with temperature probe
<input type="checkbox"/> Surgical clips/staples	<input type="checkbox"/> Transdermal med patches	<input type="checkbox"/> Blood clot filter	<input type="checkbox"/> Swan Ganz catheter
<input type="checkbox"/> Wires/plates/screws/pins	<input type="checkbox"/> Hearing aid	<input type="checkbox"/> Insulin/infusion/IV pump	<input type="checkbox"/> Dentures/ retainers/braces

IMPORTANT INSTRUCTIONS: THE MR SYSTEM MAGNET IS ALWAYS ON!!!

PLEASE REMOVE ALL BODY PIERCING/JEWELRY/HAIRPINS AND OTHER METAL OBJECTS BEFORE ENTERING THE MR PROCEDURE ROOM. YOU WILL BE REQUIRED TO CHANGE INTO A GOWN AND WEAR EARPLUGS FOR SAFETY REASONS.

Signature of person completing this questionnaire _____ Date _____ Signature of MR Staff reviewing form _____ Date _____	UMH OR MOTT INPATIENT/ER ONLY: Completed form: Adults (18+): Tube to E6 OR FAX to 734-647-7978 Peds (<18): Tube to N6 OR FAX to 734-763-2421
Form completed by: <input type="checkbox"/> Patient <input type="checkbox"/> Family (relationship): _____ <input type="checkbox"/> UMHHS Staff <input type="checkbox"/> Other: _____	