Princeton Radiology
Excellence in Imaging

MRI QUESTIONNAIRE (CHEST, ABDOMEN OR PELVIS)

Name:_____ D.O.B. ___/___/___ Sex: M/F   WT:_____ lbs

☐ *YES NO☐   Have you received a COVID vaccine? If yes, please answer the following: Pfizer/Moderna/J&J*
1ˢᵗ dose date: _____ Arm: RIGHT / LEFT   2ⁿᵈ dose date: _____ Arm: RIGHT / LEFT

Why are you having the exam? (Symptom):_____

What side, location, body part is involved? (Location):_____

How long have you had this problem? (Duration):_____

If due to injury, how did it occur? (Mechanism of Injury):_____

☐ YES NO ☐   Have you ever had a reaction to MRI contrast?

☐ YES NO ☐   Is there any chance you may be pregnant? Date of last menstrual period?_____

☐ YES NO ☐   Do you wear a Dexcom, Libre, or other glucose monitor?

☐ YES NO ☐   Do you have a history of being diagnosed with cancer Type?_____

☐ YES NO ☐   Any radiation therapy? If YES, dates?_____

☐ YES NO ☐   Any chemotherapy? If YES, dates/type?_____

☐ YES NO ☐   Did you have any prior imaging of the area being scanned in another imaging facility?
Where/when? _____

☐ YES NO ☐   Any prior surgery of the area? Type/dates?_____

☐ YES NO ☐   Are you in a lung cancer screening program with yearly CTs of the chest?

☐ YES NO ☐   Do you now or have you ever smoked?
         If **YES**, how many years did you smoke?   _____ years
         How many packs per day did you smoke?   _____ packs per day
         How long ago did you quit? If still smoking, mark as "0":   _____ years ago

FOR PATIENTS HAVING A PELVIC MRI:
Male patients:
☐ YES NO ☐   Have you had a biopsy of your prostate? When? _____   Where: _____
                                                      PSA Level = _____   Date:_____

Female patients:
☐ YES NO ☐ Have your ovaries been removed?

☐ YES NO ☐ Do you use hormone replacement therapy?   If yes, for how long**?** _____

I acknowledge that all the information given is accurate and thereby consent to have MRI with or without an injection of contrast performed on me. I do not have a pacemaker. I have removed all hearing aids, dentures, external pumps and monitoring devices.

Signature:_____ Date:___/___/___

Technologist Notes:_____

_____

Technologist Initials:_____