Park Avenue Radiologists, P.C.

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE

MRI/MRA QUESTIONNAIRE

PATIENT NAME: DOB: AGE:

Account Number: **SOCIAL SECURITY #:** FEMALE / MALE (PLEASE CIRCLE)

REFERRING PHYSICIAN/PHONE NUMBER:

IF YOU ARE PREGNANT, PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY.

ARE YOU OR COULD YOU BE PREGNANT? YES NO ________(INITIAL) DATE OF LAST MENSTRUAL CYCLE: _____/____/_____

ARE YOU CURRENTLY BREAST FEEDING? YES NO _______(INITIAL)

WHAT SYMPTOMS OR COMPLAINTS BROUGHT YOU HERE? ______________________________

____

PLEASE SPECIFY THE LOCATION AND DURATION OF SYMPTOMS: ______________________________

____

WHICH SIDE? RIGHT LEFT OTHER ______________________________

PLEASE LIST ALL PRIOR SURGERIES:

		DATE
[ ]	NONE	
[ ]	______________________________	_____/____/_________
[ ]	______________________________	_____/____/_________
[ ]	______________________________	_____/____/_________

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER OR SERIOUS ILLNESS? YES NO

IF YES, WHAT KIND? ______________________________

IF YES, HAVE YOU HAD CHEMOTHERAPY? YES NO DATES: _____/____/_____

IF YES, HAVE YOU HAD RADIATION THERAPY? YES NO DATES: _____/____/_____

DO YOU HAVE ANY ALLERGIES? YES NO IF YES, EXPLAIN ______________________________

ARE YOU OR HAVE YOU EVER BEEN A SMOKER? YES NO

IF YES, HOW MANY PACKS PER DAY? ____________

FOR HOW MANY YEARS? ______________________

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

PACEMAKER	YES	NO		
ANEURYSM CLIPS	YES	NO		
IMPLANTED CARDIAC DEFIBRILLATOR	YES	NO		
RETINAL TACK	YES	NO	IF YES, WHAT TYPE?	____________
HEARING AID	YES	NO	IF YES, WHAT KIND?	____________
COCHLEAR EAR	YES	NO	IF YES, WHAT KIND?	____________
HEART /CHEST	YES	NO	IF YES, WHAT KIND?	____________
ARTHROSCOPIC	YES	NO	IF YES, WHAT KIND?	____________
TATTOO OR BODY PIERCING	YES	NO	IF YES, WHAT KIND?	____________
INTRAUTERINE DEVICE/PESSARY	YES	NO		

HAVE YOU EVER WORKED IN A METAL OR MACHINE SHOP? YES NO

HAVE YOU EVER BEEN STRUCK IN THE EYES WITH METAL SHAVINGS? YES NO

IF YES, PLEASE EXPLAIN: ______________________________

DO YOU HAVE BULLETS, SHRAPNEL, OR OTHER FOREIGN BODIES ON OR WITHIN YOUR BODY?

IF YES, PLEASE EXPLAIN: ______________________________

ARE YOU TAKING: GLUCOPHAGE METFORMIN OR GLUCOVANCE YES NO (PLEASE CIRCLE AND INITIAL)

I ATTEST THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

______________________________ ______________

SIGNATURE OF PATIENT OR GUARDIAN OR PERSON AUTHORIZED TO CONSENT FOR PATIENT DATE

AS PART OF THIS PROCEDURE I CONSENT TO HAVE INTRAVENOUS CONTRAST MATERIAL GIVEN TO ME. THIS INTRAVENOUS CONTRAST MATERIAL IS ADMINISTERED THROUGH A NEEDLE PLACED IN THE VEIN. THE INDICATIONS AND RISKS OF THIS PROCEDURE HAVE BEEN EXPLAINED TO ME AND ALL MY QUESTIONS ADDRESSED.

______________________________ ______________

SIGNATURE OF PATIENT OR GUARDIAN OR PERSON AUTHORIZED TO CONSENT FOR PATIENT DATE

TECHNOLOGIST NOTES:

TECH SIGNATURE