**BAY COLONY**

# MR Room (Metal) Questionnaire

**Weight:** ________

TO OUR PATIENTS AND ACCOMPANYING FAMILY MEMBERS...
*The MR room contains a very strong magnet. Before you are allowed to enter, we must know if you have any metal in your body. Some metal objects can interfere with your scan or may even be dangerous, so PLEASE answer the following questions carefully. If you have a question regarding anything on this form, PLEASE DO NOT HESITATE TO ASK US!*

☐ Yes ☐ No Have you ever had an operation or surgery of any kind? If so, please list them all with dates.

______________________________

______________________________

☐ Yes ☐ No Are you claustrophobic?

☐ Yes ☐ No Have you ever been a machinist, welder, or metalworker?

☐ Yes ☐ No Have you ever been hit in the face or eye with a piece of metal (including metal shavings, slivers, bullets or BBs?)

☐ Yes ☐ No Have you ever had a piece of metal removed from your eye?

☐ Yes ☐ No Are you pregnant, possibly pregnant, or breast feeding?

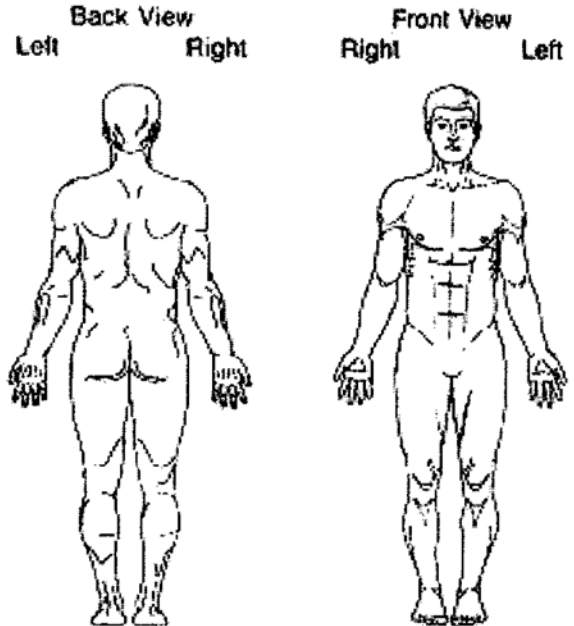
**Do you have any of these items in your body?**

☐ Yes ☐ No ***Pacemaker, wires, or defibrillator***
☐ Yes ☐ No Body piercing
☐ Yes ☐ No ***Brain aneurysm clip***
☐ Yes ☐ No Ear implant
☐ Yes ☐ No Eye implant
☐ Yes ☐ No Electrical stimulator for nerves or bone
☐ Yes ☐ No Bullets, BBs, or pellets
☐ Yes ☐ No Metal shrapnel or fragments
☐ Yes ☐ No Magnetic implant anywhere
☐ Yes ☐ No Infusion pump
☐ Yes ☐ No Coil, filter, or wire in blood vessel
☐ Yes ☐ No Artificial limb or joint
☐ Yes ☐ No Eyelid tattoo
☐ Yes ☐ No Implanted catheter or tube
☐ Yes ☐ No Artificial heart valve
☐ Yes ☐ No Penile prosthesis
☐ Yes ☐ No Shunt
☐ Yes ☐ No False teeth, retainers, or magnetic braces
☐ Yes ☐ No Surgical clips, staples, wires, mesh, or stitches
☐ Yes ☐ No Diaphragm or intrauterine device
☐ Yes ☐ No Ortho devices (plates/screws/pins /rods/wires)

The following items may become damaged or cause injury to others in a strong magnetic field. THEY MUST NOT BE TAKEN INTO THE SCAN ROOM. Please check off any of these items you may have with you today.

☐ Hearing Aid
☐ Glasses
☐ Watch
☐ Safety Pins
☐ Hairpins/barrettes
☐ Wigs/hair pieces
☐ Jewelry
☐ Wallet/money clip
☐ Metal zippers/buttons
☐ Purse/pocketbook
☐ Pens/pencils
☐ Keys
☐ Coins
☐ Pocketknife
☐ Credit or bank cards
☐ Belt Buckle/Suspenders
☐ Bra/girdle/sanitary belt

**Please mark on this drawing the location of any metal inside your body.**




## Information Concerning Gadolinium Contrast Material

*As part of your examination, the radiologist may deem it advisable to give you an I.V. injection of a contrast agent containing gadolinium. This injection may help the physician more accurately diagnose your condition. Although gadolinium contrast agents have been used safely in millions of cases, minor reactions (principally headache or nausea) occur in about 2% of patients, whereas serious or life-threatening reactions have been reported in about one in 400,000 patients.*

Have you ever had a previous allergic reaction to gadolinium contrast material? YES NO

Do you have a history of asthma or emphysema? YES NO

*I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.*

Signature (Parent or Guardian)________________
Date____________________

Witness__________________________
Date____________________

**BAY COLONY**

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Signature (Parent or Guardian)________________
Date____________________

Witness____________________________
Date____________________

**BAY COLONY**

Date of Birth:
Referring Physician:

## *Knee MRI Questionaire*

1. Is the pain located at the INSIDE or OUTSIDE part of the knee?

 ______________________________

2. Is it IN FRONT OF or IN BACK OF the knee? ______________________________

3. Is the knee cap painful? ☐ Yes ☐ No

4. Does the knee lock? ☐ Yes ☐ No

5. Does the knee swell? ☐ Yes ☐ No

6. How long have you had this problem?

 ______________________________

7. Any prior history of knee surgery? ☐ Yes ☐ No IF YES, PLEASE LIST DATE(S):__________

8. How did it occur? (e.g., accident, trauma, etc)

 ______________________________

9. Please give a brief description of the incident

 ______________________________

10. Any other imaging studies of the knee?

 X-Ray ☐ Yes CT ☐ Yes MRI ☐ Yes

 Performed at what facility? ______________________________

 Approximately what date? ______________________________

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Patient Signature______________________
Date______________________
Witness______________________
Date______________________