BATON ROUGE RADIOLOGY GROUP

Imaging Center

Telephone: (225) 769-9337

MRI EVALUATION FORM

Name: ______________________

Referring Physician: ______________________

Age: __________ Weight: __________

Exam: ______________________

Check the YES or NO response

	YES	NO
Are you pregnant?	____	____
Have you ever had:		
Metal in your eyes?	____	____
Head or brain surgery?	____	____
Have you ever done:		
Welding?	____	____
Grinding?	____	____
Machine work?	____	____
Metal Lathe work?	____	____
Have you ever had:		
Asthma?	____	____
Sickle cell anemia?	____	____
Congestive heart failure?	____	____
Diabetes?	____	____
Kidney problems or disease?	____	____
High Blood Pressure?	____	____
Do you have in or on your body:		
A cardiac pacemaker?	____	____
Aneurysm clips?	____	____
Carotid clips?	____	____
A neurostimulator?	____	____
A vena cava umbrella?	____	____
An artificial heart valve?	____	____
An insulin pump?	____	____
Wires or electrodes?	____	____
A hearing aid?	____	____
An IUD?	____	____
Any stents or shunts?	____	____
Any joint replacements?	____	____
Rods, pins or screws?	____	____
Metal plates or metal mesh?	____	____
Shrapnel or bullet fragments?	____	____
Middle ear prosthesis?	____	____
Any tatoos?	____	____
Removable dental appliances?	____	____
Any metal implants not mentioned above?	____	____

Comments: ______________________

____

Reason for exam: ______________________

____

Date of Birth: ______________________

Answer all that apply to you:

Do you have leg pain or numbness?	Yes	No
Do you have arm pain or numbness?	Yes	No
Which side: (L, R or Both)	L R	B

Describe: ______________________

____

Trauma or accident related to current problem? Yes No

____

____

Have you ever had cancer? Yes No

What type? ______________________

____

Do you have any drug allergies? Yes No

____

List all previous surgeries: ______________________

____

Please do not bring the following into the scan room ***(no metal objects) :***

Pagers	Glasses	Credit Cards
Watches	Safety Pins	Keys, Coins
Pocket Knives	Belt Buckles	Hair Pins

I realize the importance of this questionnaire and have answered all questions truthfully. Any and all questions I may have had concerning this examination have been answered and I am in agreement with having this MRI scan performed.

______________________ ____________

Patient's Signature Date

______________________ ____________

Interviewer's Signature Date

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