MRI Patient Questionnaire

Wollongong Diagnostics
Imaging Solutions at Affordable Price

Name: **Date of Birth: / /**

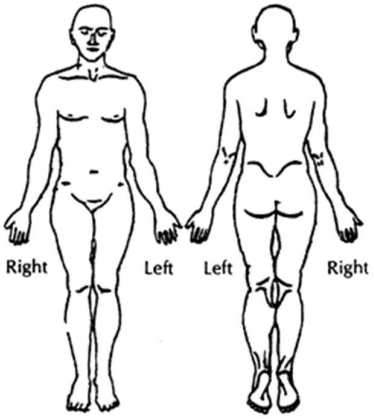
Mobile: **Approx. Weight: ____kg**

<u>If you have any queries or you do not understand a question, please ask the MRI staff</u>
Do you have (or have you ever had) any of the following (please circle):

Pacemaker:	**YES / NO**
Heart Surgery:	**YES / NO**
Brain Surgery:	**YES / NO**
Eye or Ear Surgery:	**YES / NO**
Have you <u>ever</u> had a metal injury to your eyes:	**YES/ NO**
Pacing wires / Defibrillator:	**YES / NO**
Artificial heart valve:	**YES / NO**
Intravascular Stents, coils or filters:	**YES / NO**
Brain Aneurysm Clip:	**YES / NO**
Brain Shunt Tube:	**YES / NO**
Ear Implant (Cochlear or Staples):	**YES / NO**
Neurostimulator /Biostimulator:	**YES / NO**
Any surgically implanted pump/device:	**YES / NO**
Metal Pins, plates, rods screws, prosthesis:	**YES / NO**
Have you had recent bowel surgery:	**YES / NO**
Tattoos:	**YES / NO**
Dentures:	**YES / NO**
(Male) Penile Prosthesis:	**YES / NO**
(Female) Intrauterine Device (IUD):	**YES / NO**
(Female) Could you be pregnant:	**YES / NO**

<u>List all surgery you have undergone</u>
_____
_____
_____

<u>Please shade the areas of pain and describe the symptoms</u>



<u>Clinical symptoms:</u>
_____
_____
_____

***Please <u>remove</u> all jewellery and body piercings prior to being collected by the MRI technologist**

I Confirm I have understood and answered the questions and **<u>I do not have a pacemaker.</u>**

Signature of Patient / Guardian: _____ Date: / /