



IMAGERIE MÉDICALE | MEDICAL IMAGING

WESTMOUNT SQUARE

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QUESTIONNAIRE FOR MAGNETIC RESONANCE IMAGING

Patient's name: _____

MRN: _____

1. Do you have:

- a) a cardiac pacemaker? Yes No
- b) a stent? Yes No Model: _____
- c) a clip on an aneurysm in the brain? Yes No
- d) a ear implant? Yes No
- e) an insulin pump? Yes No
- f) a neuro or bio stimulator? Yes No
- g) a foreign body in the eyes? Yes No
- h) a penile implant? Yes No
- i) Do you have breast implants? Markers, clips? Yes No Model: _____
- j) Do you wear a nicotine patch? Yes No
- k) Do you have body piercings or tattoos? Yes No
- l) Do you have permanent makeup? Yes No

2. Have you ever had heart, brain, eye or other surgery? Yes No
- _____ Year: _____ / _____ Year: _____
- _____ Year: _____ / _____ Year: _____
- _____ Year: _____ / _____ Year: _____

3. Is there any metal in your body? Have you ever had metal in your eyes? Have you ever worked in welding?
Yes No - If yes, specify: _____

4. Do you have any allergies? Yes No If yes specify: _____
If yes, specify what type of reaction: _____

5. Do you suffer from asthma? Yes No If yes specify: _____

6. Do you have cardiac problems? Yes No If yes specify: _____

7. Are you pregnant? Yes No Number of weeks: _____

Are you breastfeeding? Yes No **If yes, please sign consent**

8. Are you claustrophobic? Yes No
If yes, would you like a sedative? Yes No
If yes, you must arrive 45 min. earlier and be accompanied because it is not recommend to drive for 4 to 8 hours.

9. Are you treated for glaucoma – prostate problems – angina – arrhythmia? If yes, please circle. Yes No
If yes, additional fee might be required for certain type of abdominal and pelvic examinations.

10. Do you have any physical disability (wheel chair, etc.)? Yes No

11. How much do you weigh? _____ (Max capacity of the MRI table is 350 pounds)

Please be advised, that you will only be reimburse 50% if you decide, for whatever reason, to terminate the examination before it is finished and you will be charge for any cancellation within less than 24 hours.

Secretary: _____ Technician: _____

Patient signature: _____ Date: _____