MAGNETIC RESONANCE IMAGING (MRI)
ABDOMEN QUESTIONNAIRE

Print Name: ____________________________________________________________ Date: __________________

1.) Reason you are having this MRI scan, include any recent or new complaints:
__________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________
How long have your symptoms been present? _____________________________

2.) What are your major symptoms? (pain, mass, infection, etc…)
__________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________
For how long? _____________________________

3.) Do you have a history of cancer? _________ If yes, what type? __________________________________________________
Did the treatment include:
  Radiation therapy? □ Yes □ No
  Chemotherapy? □ Yes □ No
If yes to radiation therapy, what part of your body? __________________________  If yes, when? ______________________

4.) Have you had any other previous surgeries? _________  If yes, please list type of surgery and date:
________________________________________________________________ ________________________________________________________
________________________________________________________________ ________________________________________________________

5.) Are you scheduled or will you be scheduled in the future for a transplantation of an organ?
   If yes, what body part (or organ)? ______________________________________________________________________

6.) Have you had any previous imaging studies of this area? □ Yes □ No
   □ Type of Study: Date Facility
   Radiographs (X-rays) ___________ ________________________________________________________________
   Angiogram ___________ ________________________________________________________________
   Computed Tomography (CT) ___________ ________________________________________________________________
   Nuclear Medicine (Bone Scan) ___________ ________________________________________________________________
   MRI ___________ ________________________________________________________________
   Other ___________ ________________________________________________________________

MRI Technologists Notes:
____________________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________________

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS

51219 (Rev. 07/09)
ABDOMEN QUESTIONNAIRE
OUTPATIENT QUESTIONNAIRE/ASSESSMENT
MAGNETIC RESONANCE IMAGING (MRI) DEPARTMENT

### Patient Information and History

Name:________________________________________________________ Date of Birth: _____________  Today’s Date: ___________

Ordering Physician: ______________________________________________________________________________________________

Exam(s) being done today: ________________________________________________________________________________________

Briefly explain to the best of your knowledge the reason for this exam:________________________________________________
______________________________________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________________________________

What is the primary language spoken?________________________________________

1. Do you need assistance walking and/or standing? □ Yes □ No
2. Are you “at risk” of falling? □ Yes □ No
3. Have you had any recent falls? □ Yes □ No
   Date of recent fall: ________________________ Briefly explain: ______________________________________________________
   ______________________________________________________________________________________________________

4. Is there anyone with you today? □ Yes □ No

5. Do you have any known allergies to latex products? □ Yes □ No

6. Are you allergic to any medications? □ Yes □ No
   If yes, what type(s)?: ______________________________________________________________________________________________

7. Are you diabetic? □ Yes □ No

### Individualized Patient Care

What is one thing I can do for you to make sure you receive very good care today?
______________________________________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________________________________

Are there any special needs/considerations that we should know about?
______________________________________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________________________________
**Medication List**

Please list all medications you are currently taking:

<table>
<thead>
<tr>
<th>Date</th>
<th>Medication Name</th>
<th>Dose</th>
<th>Frequency</th>
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</thead>
<tbody>
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</tbody>
</table>

Patient / Patient Caregiver Signature

Date

Clinician Signature (i.e. Nurse)

Date

Clinical Signature (i.e. MRI Technologist)

Date
MAGNETIC RESONANCE IMAGING (MRI)
SCREENING FORM FOR PATIENTS

The information requested on this form is very important. Please answer all questions as thoroughly as possible. The patient or patient’s legally authorized representative is responsible for the accuracy of the requested information.

Patient Name (printed): _______________________________ Weight: __________ Height: __________

Do you have any of the items or conditions listed below? Please check “Yes” of “No” for each item or condition.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Pacemaker</td>
<td>Penile Implant</td>
</tr>
<tr>
<td>Implanted Cardioverter (Heart) Defibrillator</td>
<td>Neurostimulation system</td>
</tr>
<tr>
<td>Stent, Coil or Filter (circle all that apply) Location: Date:</td>
<td>Ph Graph Probe</td>
</tr>
<tr>
<td>Aneurysm Clips Location:</td>
<td>Bone growth / Bone Fusion Stimulator</td>
</tr>
<tr>
<td>Zenith Cook, (Abdominal) Stent Graft</td>
<td>Middle Ear/Cochlear Implant:</td>
</tr>
<tr>
<td>Surgical staples, clips or metallic sutures</td>
<td>Hearing Aid</td>
</tr>
<tr>
<td>Carotid Artery Clips Date: (circle all that apply) Date:</td>
<td>Prosthesis of: Joint, Extremities or Eyes</td>
</tr>
<tr>
<td>Artificial Heart Valve Date:</td>
<td>Implanted drug infusion pump</td>
</tr>
<tr>
<td>Shunt: Spinal or Ventricular</td>
<td>Medication Pump and / or Medication Patch</td>
</tr>
<tr>
<td>Thermodilution Swan-Ganz Catheter</td>
<td>Metal Fragments (Shrapnel or Gunshot wound)</td>
</tr>
<tr>
<td>Magnetically-activated implant or device? Location: Date:</td>
<td>Tattoos or Permanent makeup Location:</td>
</tr>
<tr>
<td>Silver impregnated wound dressing</td>
<td>Body Piercing Location:</td>
</tr>
<tr>
<td>Fractured bones or spine treated with: Metal Rod Date: Date of your last menstrual period:</td>
<td></td>
</tr>
<tr>
<td>Metal Plates Date: Do you have an Intrauterine device (I.U.D.)?</td>
<td>Are you Pregnant or trying to get pregnant?</td>
</tr>
<tr>
<td>Metal Pins Date: Are you currently Breast Feeding?</td>
<td></td>
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<tr>
<td>Screws Date:</td>
<td></td>
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<tr>
<td>Metal in eyes Left / Right / Both</td>
<td>Are you claustrophobic (fear of tight places?)</td>
</tr>
<tr>
<td>Eyelid spring or wire</td>
<td>Do you have any kidney problems?</td>
</tr>
<tr>
<td>Scleral buckles</td>
<td>Allergic Reactions to Intravenous (IV) Contrast?</td>
</tr>
<tr>
<td>Sickle Cell or Hemolytic Anemia</td>
<td>Ingested camera pill?</td>
</tr>
<tr>
<td>Tissue Expander Date:</td>
<td>Other implants? Date:</td>
</tr>
</tbody>
</table>

* No one should enter the MRI scan room with: • Watch • Metal Zippers • Firearms • Removable Dental Work • Pens • Hearing Aid • Keys/Coins • Pocket Knife • Hairpins • Belt Buckle • Bra • Purse, Wallet, Money Clip, Credit Cards

Signature of Person completing the form: __________________________________________

Form completed by: Patient □ Relative □ Care Giver □ Other: ___________________________

MRI STAFF: Signatures of person(s) reviewing the MRI Screening Form for Patients:

1.) ___________________ R.T. 2.) ___________________

Were X-Ray’s obtained? □ Yes □ No Date _______ Time _______ Filmed cleared by: ___________________ M.D.

Contrast Type: ______________ Amount: _______ ml Lot #: __________________ Exp. Date: _______________
BAYLOR HEALTH CARE SYSTEM  
PATIENT HISTORY FOR CONTRAST MEDIA

Patient Name: __________________________ Date of birth: ___________ Height: _______ Weight: _______

In order to assess your risk of complications and reduce risk for a contrast media allergic reaction please complete sections 1-3 below:

1. **Please indicate if you have one of the following *:**
   - [ ] History of "kidney disease" as an adult or family history of kidney problems
   - [ ] History of kidney transplant
   - [ ] History of liver disease
   - [ ] Diabetes
   - [ ] Paraproteinemia syndromes or diseases (e.g. myeloma)
   - [ ] Collagen vascular disease (e.g. Lupus)
   - [ ] Recent contrast study (e.g. within the last 7 days)
   - [ ] Recent surgeries? If yes, please list: __________________________________________________________
   - [ ] Sickle cell disease
   - Certain medications:
     - [ ] Metformin or metformin-containing drug combinations (Metformin, Avandamet, Glucophage, Glucophage XR, Actoplus Met)
     - [ ] Regular use of nephrotoxic antibiotics, such as aminoglycosides, or non-steroidal anti-inflammatory drugs (e.g. Motrin, Aleve)

   *If you checked any of the boxes above, please inform your technologist now. You may require special instructions and further blood test(s) to assess your kidney function prior to receiving intravenous (IV) contrast media.

2. **Have you ever had an allergic reaction to intravenous contrast (e.g. iodine, gadolinium)?**  
   - [ ] YES  
   - [ ] NO  
   If "YES", please describe*: ________________________________________________________________________

   *If "YES", based on your reply, you may require pre-medication prior to receiving IV contrast, no IV contrast, or alternative imaging.

3. **Do you have a history of the following medical conditions:**
   - [ ] Asthma (if you have active asthma, bronchospasm, or bronchitis requiring treatment, please inform your technologist now)
   - [ ] Cardiac Disease (angina, congestive heart failure, aortic stenosis, hypertension, primary pulmonary hypertension, severe but well compensated cardiomyopathy)
   - [ ] History of allergic (anaphylactic) reaction to one or more allergens

Signed: ________________________________________________________ Date: ____________ Time: ____________
(Patient, Parent or Guardian)

To be filled out by the technologist performing your exam

________ Exam Performed Per Protocol  _______ Exam Performed Per Physician / Name: _____________________________

Contrast IV - Type/Amount/Rate/Site: __________________________     Contrast Oral - Type/Amount:___________________

Creatinine: _______________ Result Date: _________________ Estimated Glomerular Filtration Rate: __________________

Technologist: __________________ Date: ____________ Time: ____________