

QUESTIONNAIRE FOR THE MRI EXAMINATION

LAST NAME, FIRST NAME: _____

DATE OF BIRTH: _____

WEIGHT: _____

HEIGHT: _____

Please hand over any previous images or doctor's reports of previous examinations of the body parts that need to be examined before today's examination. Please answer all the following questions carefully and complete the form!

1) What kind of complaints led you to the visit of your referring physician? (please give a short description of your symptoms)

since when: _____

2) Please indicate the side of the body that is affected.

left right

3) Have you ever undergone surgery in the area/ the organ of the body part that will be examined?

yes no WHEN _____

4) Have you been diagnosed with an acute or chronic infectious disease? (e.g. tuberculosis, AIDS, hepatitis) or do you have an impaired renal function?

yes no

5) Are you/ have you been a cancer patient?

yes no

6) Which organ is/ has been diagnosed with cancer?

OPERATION _____ WHEN _____

RADIOTHERAPY _____ WHEN _____

CHEMOTHERAPY _____ WHEN _____

7) Have you ever had incompatibilities or problems with earlier MRI examinations?

yes no

8) Have you any allergies to e.g. medicines, hay fever, food allergies or cosmetics? (if necessary show us your allergy passport!)

yes no

9) Do you suffer from claustrophobia? (anxieties in confined spaces)

yes no

Do you have any more questions? If you do have more questions, you can resolve the issues with our assistant before the examination.

Annotations of the doctor during the explanatory conversation: _____

SIGNATURE OF THE PHYSICIAN

10) Do you have a pacemaker or any other electrical devices such as an insulin pump, hearing aid, defibrillator or a neurostimulator?

yes no

11) Do you have any other pieces of metal in your body (e.g. vascular clamps, stents, metal splinters, metal prosthetics, implants, intrauterine device)? Do you have a piercing or dental prosthetics that you could take out?

yes no

If yes: What kind of metal, in which place?

12) Have you ever had a metal splinter in your eye?

yes no

13) Has this metal splinter been removed completely by an ophthalmologist?

yes no

14) Do you wear any permanent make up or tattoos?

yes no

15) Women of childbearing age:

Are you pregnant?

yes no

Are you currently nursing?

yes no

I would like to receive a copy of the completed explanatory leaflet.

DECLARATION OF CONSENT:

(Please mark with a cross)

- I have read the explanatory leaflet carefully and I am well informed about the planned examination. I confirm that I have answered all questions completely and in the best of my knowledge.
- I do not have any further questions and herewith consent to the examination after having had sufficient time to think about it.
- I consent to an injection of a contrast medium should it be necessary during the examination.

LOCATION / DATE _____

SIGNATURE OF THE PATIENT / OR GUARDIAN _____