MEDICAL QUESTIONNAIRE
BEFORE MRI EXAMINATION

neoscan

All data included in the questionnaire are medical data -
are subject to medical confidentiality and will not be used for any purpose other than medical.

COMMENTS

The patient, during the MRI examination, is in a strong magnetic field, and therefore MUST NOT have any metal objects or objects sensitive to it..
It is forbidden to bring to the studio: keys, coins, hearing aids, magnetic cards, mobile phones, watches, etc. In the event of damage to the above-mentioned items, our company is not responsible for it.
The test lasts - depending on the studied area - from several to several dozen minutes and is accompanied by a lot of noise. A very important issue is the fact that the Patient must remain motionless during the examination - each movement has a negative impact on its diagnostic value.

THE ABSOLUTE CONTRAINDICATION FOR THE TEST IS TO HAVE A HEART PACEMAKER, NEUROSTIMULATOR OR IMPLANT MADE OF FERROMAGNETIC METAL.

Name and surname: …….....

Date of birth: ….....

Address: .....

Phone number: …..... Date of examination: ….....

Weight: .....kg

Examination result (please choose one option):

☐ I will pick it up in person

☐ please send it by post to the address given above

☐ please send by e-mail to the address: ….....

Study area: ….....

Study paid by: ……..……

The patient paid: ….....

Medical history (please describe what happened, when, was there an injury, etc.)**:**

….....

.....

.....

Please fill in the questionnaire carefully and mark the correct answer by circling it with a **circle**.

Are you pregnant?	YES	NO
Do you suffer from cardiac arrhythmias, circulatory failure?	YES	NO
Have you experienced any sudden loss of consciousness?	YES	NO
Do you suffer from claustrophobia or other anxiety states?	YES	NO
Have you had an MRI scan before?	YES	NO
Was a contrast medium administered?	YES	NO
Have there been any allergic reactions to contrast media?	YES	NO
Do you have any chronic diseases? If so, please specify what	YES	NO
Have you ever had operations? If so, please specify what	YES	NO
Are you covered by hospital treatment on the day of the test?	YES	NO
Do you have valid health insurance?	YES	NO
• Do you have: • epilepsy • kidney disease (failure) • diabetes • hypertension • infectious diseases - if so, please specify what	 YES YES YES YES YES	 NO NO NO NO NO
Do you have in your body: • pacemaker • intracranial vascular clips • ventricular or spinal valves, artificial heart valves • hearing implant • dentures, dental bridges, implants • neurostimulators, an insulin pump or other drug delivery device • bone prostheses or clasps to stimulate bone growth • metal joint prostheses • metal intrauterine devices, metal filings, shards • other implanted metal elements, please specify what	 YES YES YES YES YES YES YES YES YES YES YES	 NO NO NO NO NO NO NO NO NO NO NO
I consent to the MRI scan	YES	NO
If it is necessary to perform an examination with the intravenous administration of a contrast agent, I give my consent	YES	NO

I, the undersigned, declare that I have read, understood and take full responsibility for the information provided in the questionnaire. I confirm their compliance with the facts and that I have not concealed any important information about my health, the course of treatment or medications taken so far, being fully aware of the possible consequences resulting from this fact. At the same time, I confirm that the staff of the facility explained the course of the study in an understandable and clear manner, discussed its total costs and the associated risk of complications.

….....
Place and date

….....
Signature

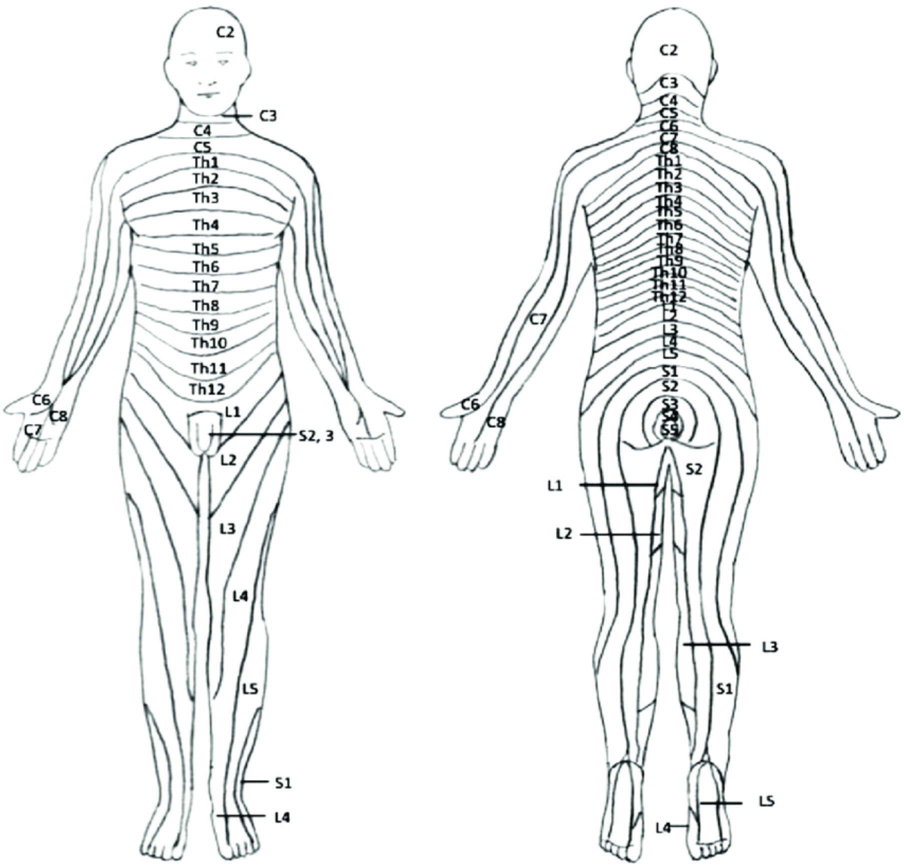
I, the undersigned, consent to the processing of my personal data included in the medical questionnaire for the purpose of carrying out an MRI examination and creating a radiological description.
The data administrator is VITA-SKAN Sp.z O.O. ul Krakusa 3-5/2. 53-319 Wrocław.

…….....
Place and date

…….....
Signature

QUESTIONNAIRE – PAIN SYNDROMES
(FOR PHYSICIAN ONLY)

- Name and Surname: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _   _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
- Date: _ _ / _ _ / _ _ _ _
- Please mark the location of the pain on the drawing / drawings:



- Does the pain radiate (YES / NO) *.
- If YES, please mark with an arrow the radiation of pain.
- Pain is on the RIGHT / LEFT side *
- When did it occur for the first time? _

Whether the pain is present all the time (YES / NO).

If NO, how often the pain occurs (how many times during the day / week / month) and how long the pain episode lasts (several minutes / hours):_ _

What is the type of the pain (BURNING / STINGING / STUBBING / COMPRESSING) *