M.R.I. Patient History and Safety Screening

Name ____ Weight____________
(Last) (First) (Middle Initial)

Age ______ Date of Birth ______________ Referring Physician ___________________

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

YES	NO	
____	____	Cardiac Pacemaker/Internal Defibrillator
____	____	Cochlear Implants
____	____	Aneurysm Clips or Internal Medical Clips
____	____	Artificial Heart Valve
____	____	Insulin Pump
____	____	Electrodes
____	____	Any Internal Electrical Devices (If yes. What? _______________)
____	____	TENS Unit or Pain Stimulating Unit
____	____	Hearing Aids
____	____	Metal Fragments in Head, Eye or Skin
____	____	Have you ever worked with metal or as a welder?
____	____	Metal Fragments, Pins, Screws, Nails or Clips
____	____	Eyeliner Tattoos
____	____	Is there any chance that you are pregnant? (Not recommended for women in their first trimester of pregnancy)
____	____	Do you have any allergies or ever had a reaction to a medication? Explain: ____
____	____	Any Previous Surgery? Please List: _________________________ ____
____	____	Current Medications: Please List: __________________________ ____

Signature of Patient:___________________________

Signature of Parent/Guardian:___________________

Date: _____________