

## M.R.I. Patient History and Safety Screening

Name	WeightAge
(Last)	(First)
Date of Birth	Referring Physician
****PLEASI	E 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
	(foreign body, shrapnel)
	Have you ever worked with metal or as a welder?
	Metal Fragments, Pins, Screws, Nails or Clips
	Eyeliner Tattoos
	Any chance of pregnancy (Not recommended for women in their first trimester of pregnancy)
ature of Patient: _	*** Attention –
ature of Parent/Gu	nardian: Please complete sign
	two *** ©