Patient History and Safety Screening
MRI PATIENTS ONLY

Name: _____
Last *First* *Middle Initial*

Age: _____ **Date:** _____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

YES	NO	
_____	_____	CARDIAC PACEMAKER
_____	_____	BRAIN VESSEL CLIPS
_____	_____	AORTIC CLIPS
_____	_____	HEART VALVE
_____	_____	INSULIN PUMP
_____	_____	ELECTRODES
_____	_____	TENS UNITS OR PAIN STIMULATING UNIT
_____	_____	HEARING AIDS
_____	_____	METAL FRAGMENTS IN THE HEAD, EYE OR SKIN
_____	_____	HAVE YOU EVER WORKED WITH METAL OR AS A METAL WORKER?
_____	_____	METAL PLATES, PIN, SCREWS, NAILS OR CLIPS
_____	_____	ANY PREVIOUS SKULL SURGERY
		IF YES, WHAT WAS THE SURGERY FOR: _____

_____

_____

_____

_____	_____	IS THERE ANY CHANCE YOU ARE PREGNANT? (Not recommended for women in their first trimester of pregnancy)

Signature of Patient: _____

Signature of Parent or Guardian: _____

Date: _____

(PATIENTS HAVING ANKLE/FOOT STUDY, PLEASE COMPLETE REVERSE SIDE)

Name: _____
Last *First* *Middle Initial*

Age: _____ **Date:** _____

Ankle/Foot Evaluation

1. What was your chief complaint when you visited your doctor?

   _____

2. What do you think caused the problem? _____

   _____

3. What does your doctor think is causing your ankle/foot problem? _____

   _____

4. Describe your pain _____

   _____

   a. Does anything make the pain worse? _____

      _____

   b. Does anything make it better? _____

      _____

5. Do you have any weakness? _____ Where? _____

   _____

6. Have you had ankle/foot surgery? _____

   When? _____

   What was done? _____

7. Have you ever broken any bones in your ankle/foot? _____

8. Do you have arthritis in any of your joints? _____

9. Do you have any other medical conditions? _____

   _____

10. Describe your general health. _____

    _____

    _____