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 BRAIN STUDY, PLEASE COMPLETE REVERSE SIDE)

Name: _____
Last *First* *Middle Initial*

Age: _____ **Date:** _____

Brain Evaluation

1. In one sentence, describe what made you go to see your doctor? _____

2. Do you have headaches? _____ If so, describe: _____

3. Do you have weakness? _____ If so, where? Which side? _____

4. Have you had seizures _____ If so, what kind? _____

5. Do you have difficulty walking? _____ If so, can you describe it? _____

6. Is your vision normal? _____ If not, can you describe the problem? _____

7. Did the difficulty come on gradually Over years? Months? Weeks? Days? Suddenly? (Circle One)

8. Have you had surgery? _____ If so what was done? When was it done? _____

9. Do you have difficulty thinking _____ Remembering? _____ Calculating? _____

10. Have you had difficulty thinking of the right words? _____ Saying word? _____

11. Have you had difficulty with your balance? _____

12. Describe your health: _____

13. Do you have allergies or Asthma? _____ Have you ever had a reaction to x-ray dyes or contrast agents? _____

14. Do you have any medical condition that we should know about? _____

15. Are you taking any medications? _____ What kind? _____