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: _____

Name: _____
Last *First* *Middle Initial*

Age: _____ **Date:** _____

Chest _____ **Abdomen** _____ **Pelvis** _____

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

2. What does your doctor think is causing your problem? _____

3. Describe your symptoms: _____

   A) Does anything make it better? _____

   B) Does anything make it worse? _____

4. How long have you had these symptoms? _____

5. Do you have any weakness? _____

6. Have you had surgery to this area? _____

   If yes, describe: _____

7. Have you had other tests for this area? _____

   If yes, describe: _____

8. Do you have any other medical conditions? _____

9. Are you taking any medications? _____

10. Describe your general health: _____

Please shade in areas of pain in picture below