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 KNEE STUDY, PLEASE COMPLETE REVERSE SIDE)

Name: _____ **Age:** _____ **Weight:** _____
Last *First* *Middle Initial*

Referring physician: _____ **Physician's Phone:** _____

Knee Evaluation

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

   _____

2. What do you think caused your knee problem? _____

   _____

3. Describe your pain _____

   _____

   a. Does anything make the pain worse? _____

   _____

   b. Does anything make it better? _____

   _____

   _____

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

   _____

5. Have you had knee surgery or arthroscopy? _____

   When: _____

   What was done? _____

6. Have you ever broken or dislocated any bones in your knee? _____

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

8. Do you have any other medical conditions? _____

   _____

9. Do you smoke cigarettes? Yes _____ No _____

10. Describe your general health. _____

    _____

    _____

Please shade in areas of pain in picture below