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 SPINE STUDY, PLEASE COMPLETE REVERSE SIDE)

Name: _____
Last *First* *Middle Initial*

Age: _____ Date: _____

Spine 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 back pain? _____

   _____

4. Describe your pain (e.g., burning, sharp, etc.) _____

   _____

5. Does the pain go down your arm? _____ Your leg? _____ In the back or front? _____

   Left, right or both? _____

6. a. Does anything make the pain worse (e.g., standing, sitting, lying down, etc.)? _____

   b. Does anything make it better? _____

   _____

7. Do you have any numbness? _____ Where? _____

   _____

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

   _____

9. Have you had any bowel or bladder changes? _____

   Describe: _____

   _____

10. Have you had back surgery? _____

    When? _____

    What was done? _____

    _____

11. Are you taking any medicines? _____

    What kind? _____

12. Do you have any other medical conditions? _____

    _____

    _____

13. Do you exercise regularly? _____ What type? _____

    _____

14. Describe your general health? _____

    _____

    _____

    _____

Please shade in areas of pain in picture below