NAME: _____ Current height: _____ Current weight: _____

Do you have a Cardiac Pacemaker, ICD, Bladder Pacemaker or Pacemaker leads? ☐ Yes ☐ No
If you have a Pacemaker is it MRI conditional? ☐ Yes ☐ No
Do you have a Cochlear Ear Implant or any type of ear implant? ☐ Yes ☐ No
Dental Implant held in place by a Magnet? ☐ Yes ☐ No
Swan-Ganz Thermodilution catheter? ☐ Yes ☐ No

Please contact the MRI department prior to continuing if you answer yes to any of the above questions.

MRI department must be contacted if you answer yes to any of the following as more information may be needed to determine compatibility and patient safety.

Are you claustrophobic? ☐ Yes ☐ No
Do you have an Implanted Stimulator Device? ☐ Yes ☐ No
Do you have an Implanted Drug Infusion Device? ☐ Yes ☐ No
Do you have an Insulin pump? ☐ Yes ☐ No
Do you have a Vascular/Cardiac stent, access port or catheter? ☐ Yes ☐ No
Do you have Aneurysm clips, Hemostatic or Vascular clips? ☐ Yes ☐ No
Do you have a Ventricular Shunt? ☐ Yes ☐ No
Do you have a heart valve repair or replacement? ☐ Yes ☐ No
Do you have an IVC filter or wire mesh implant? ☐ Yes ☐ No
Are you wearing any Transdermal Drug Patches? ☐ Yes ☐ No
Do you have an Eye implant? ☐ Yes ☐ No
Do you have a Penile implant? ☐ Yes ☐ No

Please answer Yes or No to all Questions.

Do you have any type of prosthesis or joint replacement? ☐ Yes ☐ No
Have you had to swallow a Pillcam for endoscopy/colonoscopy? ☐ Yes ☐ No
Do you have any gastrointestinal clips? ☐ Yes ☐ No
Have you ever done metal welding, cutting, grinding, etc..? ☐ Yes ☐ No
Have you ever had metal in your eyes? ☐ Yes ☐ No
Do you wear a hearing aid? ☐ Yes ☐ No
Do you have shrapnel, bullets, BB's or any other foreign metal in your body? ☐ Yes ☐ No
Do you have any body piercings? ☐ Yes ☐ No
Do you wear dentures or partial plates? ☐ Yes ☐ No
Do you have any magnets in or on your body? ☐ Yes ☐ No
Do you have permanent makeup or tattoos? ☐ Yes ☐ No
Have you ever had cancer? ☐ Yes ☐ No
If yes, what kind? _____
Women Only… Do you have an IUD? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No

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Have you had an operation on **the part of the body we are examining?**..... ☐ Yes ☐ No

Have you ever injured the part of **the body we are examining?** ..... ☐ Yes ☐ No
If yes, when and how? _____

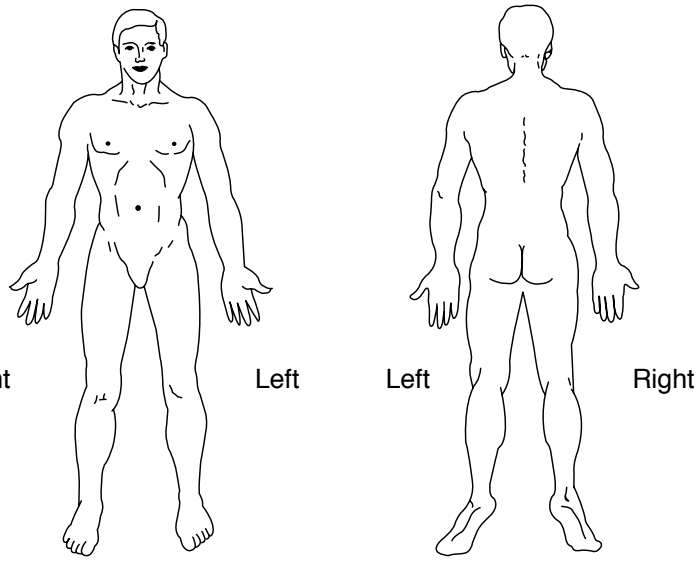
Have you had **this part of your body** examined in **radiology** before?..... ☐ Yes ☐ No
If yes, what? ☐ X-ray ☐ MRI ☐ CAT Scan ☐ Ultrasound
Where? _____ Date of most recent X-ray, MRI, Cat Scan or Ultrasound _____

Have you had organs removed? ..... ☐ Yes ☐ No
If yes, please check all that apply:

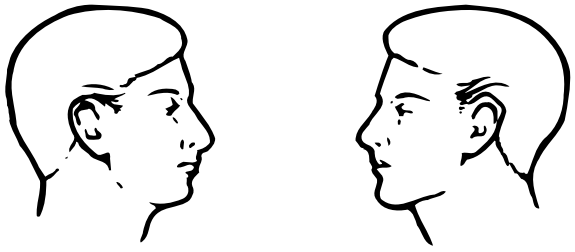
☐ Ovaries ☐ Kidney ☐ Bladder ☐ Pancreas ☐ Gall bladder
☐ Appendix ☐ Part of colon ☐ All of colon ☐ Part of small bowel
☐ Uterus ☐ Part of lung ☐ Other (please specify) _____

Please indicate on the diagrams where your symptoms are

Pain (P)
Numbness (N)
Tingling (T)
Weakness (W)



Specify: Pain (P), Numbness (N), Stiffness (S)



Please indicate if you have any of the following:

Headaches	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Speech Problems	☐ Yes	☐ No
Difficulty thinking	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Difficulty Walking	☐ Yes	☐ No
Balance Problems	☐ Yes	☐ No
Hearing Problems	☐ Yes	☐ No
Visual Problems	☐ Yes	☐ No

I agree that the above questions have been answered to the best of my knowledge.

Patient Signature: _____ **Date:** _____ **Time:** _____

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