Patient Name: _____ **DOB:** _____

HEIGHT: _____ **WEIGHT:** _____

PLEASE CHECK ALL THE OPTIONS IN THIS SECTION WHICH APPLY OR MAY APPLY TO THE PATIENT

*Please indicate whether each of the following applies to the patient. If the answer is yes to any of the following the **MRI CANNOT BE DONE:***

	Yes	No
Implanted insulin or medication pump	☐	☐
Implanted neuro-stimulator (tens)	☐	☐
Do you currently have a pacemaker	☐	☐
Have you had a pacemaker removed	☐	☐
Defibrillator	☐	☐
Magnetic dental implants	☐	☐
Magnetic artificial eye	☐	☐

*Please indicate whether each of the following applies to the patient. If the answer is yes to any of the following the **MRI CAN BE DONE:***

	Yes	No
Previous spine surgery	☐	☐
Heart bypass surgery (6 weeks post)	☐	☐
Cataract surgery (6 weeks post)	☐	☐
Gallbladder surgery (6 weeks post)	☐	☐
Joint replacement/orthopedic hardware	☐	☐
Body piercing	☐	☐
Dentures	☐	☐
Hearing aid	☐	☐
Latex allergies / risk for latex allergies	☐	☐
Claustrophobic	☐	☐
Transdermal patch medication and/or nicotine	☐	☐
Itching, hives, running nose, eye irritation, wheezing after contact with rubber products?	☐	☐

Examples: rubber gloves, balloons, diaphragms or condoms

*Please indicate whether each of the following applies to the patient. If the answer is yes to any of the following the MRI **MAY NEED TO BE** discussed with the Radiologist first: (Manufacturer, model and make of any implanted devices must be known)*

	Yes	No
Brain surgery	☐	☐
Brain aneurysm clips	☐	☐
Inner ear implant	☐	☐
Pregnant or may be pregnant?	☐	☐
Breast feeding	☐	☐
Retina repair clips	☐	☐
Heart valve	☐	☐
Implanted shunts or ports	☐	☐
Penile implants	☐	☐
Shrapnel or other metal particles	☐	☐
Metal grinding/welding	☐	☐
Tattooed eyeliner	☐	☐
Previous reaction to (MRI) contrast	☐	☐
Kidney disease, single kidney	☐	☐
Currently on dialysis	☐	☐
Multiple myeloma	☐	☐
Medication for high blood pressure	☐	☐
Diabetic	☐	☐
Surgical dressing containing silver	☐	☐

_____ _____

Patient Signature **Date** **Technologist Signature** **Date**