

NAME: _____ DATE: _____

PLEASE DESCRIBE IN DETAIL YOUR SYMPTOMS AND HOW LONG YOU HAVE HAD THEM.

IF YOU ARE HERE BECAUSE OF AN INJURY, PLEASE DESCRIBE YOUR INJURY.

HAVE YOU EVER HAD SURGERY FOR THIS PROBLEM? YES _____ NO _____

WHAT IS YOUR WEIGHT? _____ WHAT IS YOUR HEIGHT? _____

CIRCLE CORRECT ANSWER BELOW.

- YES NO Do you have a pacemaker?
- YES NO Have you ever had metal fragments in your eyes? If yes have they been removed? When? _____
- YES NO Have you ever had brain surgery? If yes, do you have brain clips? _____
- YES NO Have you ever had surgery on your spine? If yes, when? _____

IF YOU ANSWERED YES TO ANY OF THESE QUESTIONS, PLEASE NOTIFY THE STAFF BEFORE CONTINUING.

- YES NO Do you have removable dental work?
- YES NO Do you have asthma, or trouble breathing?
- YES NO Are you claustrophobic?

THE FOLLOWING ITEMS CAN INTERFERE WITH MRI IMAGING AND SOME MAY JEOPARDIZE YOUR SAFETY. PLEASE CHECK ANY OF THESE ITEMS YOU HAVE IN YOUR BODY.

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| _____ AORTIC CLIPS | _____ JOINT REPLACEMENTS | _____ WIRE SUTURES |
| _____ CAROTID CLIPS | _____ BONE OR JOINT PINS | _____ METAL MESH |
| _____ HEART VALVE REPLACEMENT | _____ SHRAPNEL/BB'S/BUCKSHOT | _____ PROTHESIS |
| _____ INSULIN PUMP/PORT | _____ INFUSION PUMP (PORTA CATH) | _____ HEARING AIDS |
| _____ COCHLEAR EAR IMPLANT | _____ SHUNT IN BRAIN | _____ NICOTINE PATCH |
| _____ ANY OTHER METAL OR FOREIGN BODY, DESCRIBE _____ | | _____ PENILE IMPLANT |

WOMEN ONLY

- YES NO Are you pregnant at this time?
- YES NO Do you have an IUD? If yes, what kind? _____

PLEASE READ AND SIGN IF APPLIES.

I DO NOT HAVE A PACEMAKER, NOR HAVE I HAD SURGERY REQUIRING ANEURYSM CLIPS. I DO NOT HAVE COCLEAR IMPLANTS IN THE EAR, NOR DO I HAVE METALLIC FOREIGN BODIES IN THE EYE. I AM FULLY AWARE THAT IF I HAVE ANY OF THE ABOVE, AN MRI/MRA SCAN COULD BE HAZARDOUS TO MY HEALTH. THE ABOVE QUESTIONS HAVE BEEN ANSWERED TRUTHFULLY AND I AGREE TO THE MRI/MRA STUDY.

PATIENTS SIGNATURE _____ DATE _____