



Patient Name _____

Weight _____ Height _____ Are you claustrophobic? _____

Patient History-check all that apply

- | | | |
|--|---|---|
| <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Brain clips | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Heart valve replacement | <input type="checkbox"/> Shrapnel | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Metal sliver in eyes | <input type="checkbox"/> Piercing other than ears | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stents | <input type="checkbox"/> IUD | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Shunts | <input type="checkbox"/> Electrodes | <input type="checkbox"/> Renal Disease |
| <input type="checkbox"/> Inner ear prosthesis | <input type="checkbox"/> Insulin/Morphine pump | <input type="checkbox"/> (Kidney) |
| <input type="checkbox"/> Neurostimulator | <input type="checkbox"/> Wire sutures | <input type="checkbox"/> Wheelchair/walker |
| <input type="checkbox"/> Hearing aids | <input type="checkbox"/> Eye line tattoos | <input type="checkbox"/> Capsule Endoscopy |

Previous MRI/MRA study? If yes please provide when and where last scan was done

Previous CT Study? If yes please provide when and where last scan was done

Please list all the surgeries you have had especially on area to be studied today.

Patient Signature _____ Date _____