

Patient Name _____

Weight _____ Height _____ Are you claustrophobic? _____

Patient History- check all that apply

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Tremors | <input type="checkbox"/> Fractured bones treated with pins, plates, screws, nails or clips | <input type="checkbox"/> Neurostimulator |
| <input type="checkbox"/> Harrington rod | <input type="checkbox"/> Eye line tattoos | <input type="checkbox"/> Shunts | <input type="checkbox"/> Oxygen tank |
| <input type="checkbox"/> Carotid clips | <input type="checkbox"/> Heart valve replacement | <input type="checkbox"/> Electrodes | <input type="checkbox"/> Wire sutures |
| <input type="checkbox"/> Metal mesh | <input type="checkbox"/> Piercing other than ears | <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Nursing home/Assist living |
| <input type="checkbox"/> Brain clips | <input type="checkbox"/> Stents | <input type="checkbox"/> Inner ear prosthesis | <input type="checkbox"/> Hearing aids |
| <input type="checkbox"/> Shrapnel | <input type="checkbox"/> IUD | <input type="checkbox"/> Cancer | <input type="checkbox"/> Able to move self |
| <input type="checkbox"/> Aortic clips | <input type="checkbox"/> Wheelchair/Walker | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Dentures |
| <input type="checkbox"/> Metal silver in eyes | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Insulin/Morphine pump | |

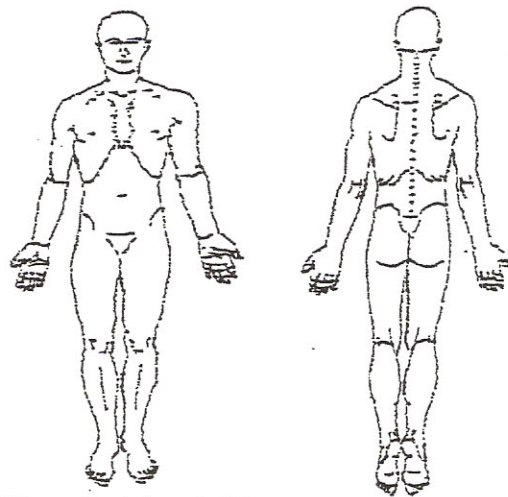
Previous MRI/MRA study? If yes please provide when and where scan was done

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

Please list all the surgeries you have had in the past (as far back as possible)

Please Check	Right	Left	Both
Arm pain			
Neck pain			
Back pain			
Leg pain			
Tingling			
Numbness			
Weakness			
Burning			

Other symptoms please describe:



Please shade in painful areas

Patient Signature _____

Date _____