



Patient name: _____
(please print)

Date of birth: _____ Sex: M F

Weight: _____

Date: _____

It is VERY IMPORTANT that you list ALL prior surgeries here.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Has the patient had previous brain surgery or a pacemaker? Yes No

Has the patient ever been a machinist, welder or metal worker? Yes No
If yes, a set of orbit films will be required.

Has the patient ever had metal or other foreign bodies in the eye? Yes No

Are any correlating films or previous MRI exams available? Yes No

Is there any chance of pregnancy or is the patient breast feeding? Yes No

Is the patient claustrophobic? Yes No

Do you have any of the following devices or items in or on your body:

Pacemaker, pacemaker wires or a cardiac defibrillator Yes No

Aneurysm clips Yes No

Electric stimulator for nerves or bones Yes No

Internal temperature probe Yes No

Bivona cuffless tracheal tube Yes No

Swan-Ganz catheters Yes No

Orbital/eye prosthesis Yes No

Ear implants Yes No

Coil, filter, wire in blood vessels Yes No

Tattoo or body piercing Yes No

Any type of foreign body, shrapnel, BBs, bullets Yes No

False teeth, retainers or dentures Yes No

Penile prosthesis Yes No

Diaphragm or intrauterine device Yes No

Medication patch Yes No

Wire mesh Yes No

Hearing aid Yes No

Skin staples Yes No

Any other implanted item(s) Yes No

If yes, please list _____

I have read and understand the above information and agree to proceed with the diagnostic study. I have reported the presence of any of the above conditions and/or devices to the technologists and physicians conducting my study.

Signature _____

Date: _____

