HIGH FIELD OPEN MRI PATIENT DATA SHEET

NAME_____DATE_____

SS#_____ Date of Birth_____

AGE_____ SEX_____ HEIGHT_____ WEIGHT_____

REFERRING PHYSICIAN_____

PLEASE ANSWER THE FOLLOWING:			**DESCRIPTION**
HEART PACEMAKER	YES	NO	_____
INTERCRANIAL ANEURYSM SURGERY	YES	NO	_____
SHRAPNEL OR METALLIC FOREIGN BODY	YES	NO	_____
REMOVABLE DENTAL WORK OR BRACES	YES	NO	_____
HEARING AIDS	YES	NO	_____
METALLIC EAR/EYE IMPLANTS	YES	NO	_____
ARTIFICIAL HEART VALVE	YES	NO	_____
HISTORY OF CANCER (SELF)	YES	NO	_____
RADIATION TREATMENTS (Specify area of body)	YES	NO	_____
NERVE OR SPINAL STIMULATORS	YES	NO	_____
SURGERY IN THE AREA TO BE SCANNED	YES	NO	_____
PREGNANT	YES	NO	_____

PATIENT SIGNATURE_____

FOR TECHNOLOGIST USE ONLY

PREVIOUS FILMS/REPORTS _____

CHIEF COMPLAINT_____

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