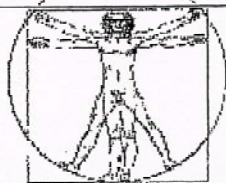


# DIAGNOSTIC OUTPATIENT IMAGING



NAME: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ AGE: \_\_\_\_\_

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Have you had an MRI before?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have a PACEMAKER/implanted defibrillator?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any implanted devices in your body?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you wear a hearing aid?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have removable dentures?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have a cochlear implant?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have a brain aneurysm clip?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have your eyes been exposed to metal fragments?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have any shrapnel or bullets in your body?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have an artificial limb/prosthesis in your body?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have a vena cava filter?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Are you pregnant?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have a history of cancer?<br>What type? _____                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Any history of brain surgery? (OR any other surgeries?)<br>What was done? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Any body piercing or permanent eyeliner?<br>Where? _____                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Are you claustrophobic?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are you allergic to any medications?  | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Signature: \_\_\_\_\_ Tech Initial \_\_\_\_\_

Patient History : \_\_\_\_\_

**FOR TECH USE ONLY**

ORAL SEDATION GIVEN: XANEX / CHLORAL HYDRATE TIME GIVEN \_\_\_\_\_

DOSAGE OF ORAL SEDATION: \_\_\_\_\_ Reaction: \_\_\_\_\_