HEAD EVALUATION

Last Name:	First Name:	Date:

THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY

1. Have you had an MRI or CT scan of this body part previously? Yes or No (circle one)
- If so, where and when?_____

2. Describe what made you go see your doctor: _____
_____
_____

3. Do you have headaches? Yes or No (Circle one) If yes, where are they located?_____
_____

4. Have you had seizures or other central nervous system deficit (stroke, fainting, etc.)? Yes or No (Circle one) If so, what type of CNS deficit?_____

5. Have you had any changes in vision, speech, balance or thinking? Yes or No (Circle one) If so, describe:_____
_____

6. Do you have a history of cancer? Yes or No (Circle one) If yes, what type?_____

Have you undergone cancer treatment(s)? Yes or No (Circle one) Type:_____

When did you have treatment(s) for cancer? _____

7. Have you had surgery to your head? Yes or No (Circle one)
When?_____

8. Do you have any other medical conditions? Yes or No (Circle one) If so, list:_____
_____

9. Are you taking any medications? Yes or No (Circle one) If so, list:_____
_____

10. Have you had any trauma to your head(e.g. car accident, fall)? Yes or No (Circle one)
When?_____

Please fill out back of this form

California Pacific Advanced Imaging

MRI SAFETY SCREENING QUESTIONNAIRE

Weight_____

Please provide a "yes" or "no" answer for every item

YES	NO	
☐	☐	Heart pacemaker or implanted cardioverter defibrillator (ICD)
☐	☐	Aneurysm clip/coil Date of implant:_____
☐	☐	Internal electrodes or wires (pacing wires, DBS or VNS wires)
☐	☐	Eye injury from a metal object (metal shavings, metal slivers)
☐	☐	Artificial eye and/or eyelid spring
☐	☐	Electronic implant/device or magnetically activated implant/device
☐	☐	Neurostimulator/spinal cord stimulator/bone growth stimulator/deep brain
☐	☐	Implanted drug pump (chemotherapy, pain medicine) ☐ External drug pump
☐	☐	Metallic stent If yes, what kind_____ Date of Implant:_____
☐	☐	Cochlear implant, middle ear implant
☐	☐	Artificial heart valve, coil, filter If yes, then list_____
☐	☐	Prosthesis of any kind (eye, ear, penile, limb) If yes, then list_____
☐	☐	Shunt ☐programmable/adjustable shunt or a ☐non-programmable shunt
☐	☐	Injured by a metal object (shrapnel, bullet, BB)
☐	☐	Medication patch (nitroglycerin, nicotine, contraceptive, estrogen)
☐	☐	Breast tissue expander
☐	☐	Surgical clips, staples or mesh implants
☐	☐	Implanted post-surgical hardware (pins, rods, screws, plates, wires)
☐	☐	False teeth/dentures, partial plates, removable dental work, braces, retainer
☐	☐	Body piercing jewelry, tattoos, permanent makeup
☐	☐	Hearing aid(s) *Remove prior to entering MRI room*
☐	☐	Other Implant If yes, then list_____

***For patient getting contrast*: Do you have a history of:**

Yes	No		Yes	No	
☐	☐	Kidney disease	☐	☐	Liver disease
☐	☐	Diabetes	☐	☐	High Blood Pressure
☐	☐	Chemotherapy in last 30 days	☐	☐	Allergic to MRI contrast
☐	☐	*Female patients only*: Are you pregnant or breast feeding?			

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

PATIENT SIGNATURE	DATE
PERSON COMPLETEING THE FORM/RELATIONSHIP TO PATIENT	TECHNOLOGIST INITIALS:

☐ **Copy of report to any other physicians:**_____