



DESERT MEDICAL IMAGING

# PATIENT HISTORY AND SAFETY SCREENING FOR MRI PATIENTS

NAME \_\_\_\_\_ Today's Date \_\_\_\_\_  
Last First MI

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

YES

NO

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- Cardiac Pacemaker
- Aneurysm Clips
- Morphine Pump
- Heart Valve
- Insulin Pump
- Electrodes
- TENS Units or Neurostimulating Unit
- Hearing Aids or Cochlear Implant
- Metal Fragments in the Head, Eye or Skin
- Have you ever worked with metal or as a metalworker?
- Metal Plates, Pins, Screws, Nails or Clips
- Previous Brain Surgery
- If yes, what was the surgery for? \_\_\_\_\_

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- IS THERE ANY CHANCE YOU ARE PREGNANT?
- HISTORY OF ALLERGIES? Please specify: \_\_\_\_\_

## PATIENT FILM RELEASE AUTHORIZATION

I HEREBY AUTHORIZE \_\_\_\_\_ TO RELEASE TO:  
(PHYSICIAN, HOSPITAL OR HEALTH CARE PROVIDER)

### DESERT MEDICAL IMAGING

PREVIOUS COMPARISON FILMS FOR THE IMAGING EXAMINATION(S) DESCRIBED ABOVE.

ON \_\_\_\_\_  
(PATIENT NAME)

DATE \_\_\_\_\_  
(SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE)