MRI PATIENT HISTORY/INFORMATION SHEET

Name _____

Patient Label

PRE-MRI ASSESSMENT
The following questions will help us determine your safety in the MRI scanner

Yes _____ No_____	
Yes _____ No_____	
Yes _____ No_____	
Yes _____ No_____	

STOP HERE if you have answered **YES** to any of the questions asked above!!

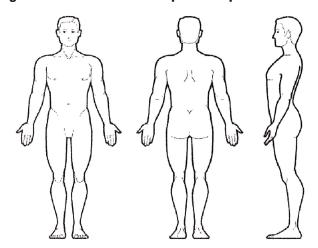| Yes _____ No_____	
Yes _____ No_____	
Yes _____ No_____	
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Yes _____ No_____	
Yes _____ No_____	
Yes _____ No_____	
Yes _____ No_____	
Yes _____ No_____	
Yes _____ No_____	
Yes _____ No_____	
Yes _____ No_____	
Yes _____ No_____	

Patient History

Use Diagram to show location of problem/pain

Check box if you have any of these symptoms related to area being scanned: *L/R indicates side of body

✓	Abdomen/Pelvis		✓	Spine			✓	Brain			✓	Joint/MSK
									L/R			
					L/R				L/R			
					L/R				L/R			
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									L/R			

I have read the above information, and answered the questions to the best of my knowledge.

Signature:_____   Date:_____