General Safety Screening, Medical History and Radiological Form

Patient Name ________________________ DOB: ______________

Please check YES or NO to the following questions

Do you have any electronic devices implanted in your body? (pacemakers, defibrillator) YES NO

*****IF YES, STOP AND SEE RECEPTIONIST IMMEDIATELY*****

Do you have any allergies to IV contrast? (IV dye or Iodine).. YES NO

Have you had any heart surgery or head surgery?.. YES NO

Do you have a history of multiple myeloma?.. YES NO

Do you have any implants in your body (i.e. pain pump, DBS, insulin pump)?.............................. YES NO

Do you have any ear or eye transplants?.. YES NO

Do you have any surgical clips?.. YES NO

Do you have any fillings or dentures?.. YES NO

Do you have any metal in your body from an accident or injury?.. YES NO

Have you ever had any metal in your eyes from an accident or welding?.................................... YES NO

Do you have a hearing aid?.. YES NO

Do you have any tattoos or body piercings?.. YES NO

Do you have a history of smoking?.. YES NO

If you answered YES to any of the above questions, list what metal objects are inside your body:

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Are you pregnant or breast feeding?.. YES NO

******IF YES, STOP AND SEE RECEPTIONIST IMMEDIATELY******

Are you taking any type of chemotherapy?.. YES NO

Do you or any family member have any kidney problems or removal?................................ YES NO

If YES, have you had Creatinine and BUN levels within the past 30 days? ______________

Are you on a transplant list or have you had a liver transplant?.. YES NO

If YES, date of transplant: ______________

Please list any diagnoses you may have or had, such as **Leukemia, M.S., Diabetes, Cancer**, etc:

____

Previous surgeries and dates: ______________________________

Any food or medication allergies? ______________________________

Why are we doing the scan? ______________________________

____

Have you had an MRI or CT Scan or surgery on the area we are scanning today?........................ YES NO

If YES, when and where? ______________________________

Do you have a follow-up appointment scheduled with your physician?.. YES NO

If YES, when and where? ______________________________

Height: ____________ Weight: ________

Signature: ________________________ **Date:** ______________