

## **MRI MEDICAL REVIEW**

Please answer all questions carefully and completely. The following items can interfere with the MRI study and your safety.
Information must be provided by capable patient or family member with knowledge of patient history.

Weight:	eight:								
				Yes	No	What, When, V	Vhere (if a	pplicab	le)
Do you use a lift at home?									
Do you now, or have you ever, had a pacemaker or defibrillator?									
Have you had heart, ear or eye surg									
Have you had surgery for an aneurysm?									
Do you have an implanted pump, stimulator, electrodes or electronic device?									
Do you have stents, coils, filters, clips or grafts?									
Will you have had an endoscopy or colonoscopy procedure performed within 6 weeks prior to this appointment?									
Have you ever sought medical attention to have metal removed from your eyes?									
Is there a possibility you are pregnant?									
Are you on dialysis?									
Do you have diabetes, Lupus, history of kidney or heart disease, TIA, stroke or poor circulation to the legs or other parts (excluding varicose veins)? Please specify.									
Please list any allergies:	Todoc opt	cony.							
Trouble not any unergroot.									
Please list all surgeries:									
Please list all surgeries:									
<u> </u>	Yes	No	Do you h	nave:				Yes	No
Do you have:	Yes	No	<b>Do you h</b> A shunt o		ath			Yes	No
<u> </u>	Yes	No	A shunt o	r portac		), diaphragm or pess	ary	Yes	No
<b>Do you have:</b> Breast implants/penile implant	Yes	No	A shunt o	r portaci trauterin	e device)	), diaphragm or pess	ary	Yes	No
<b>Do you have:</b> Breast implants/penile implant Hearing aid	Yes	No	A shunt o	r portaci trauterini breast fe	e device) eding?		ary	Yes	No
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