Prescreening Questions

Patient Name: _____ Date: _____

□ Yes □ No Claustrophobic? Sedation: _____

□ Yes □ No Are you now or have you ever worked with metal cutting, grind or welding?

□ Yes □ No Do you now or have you ever had any metal foreign bodies in you or removed from you? (Example: Bullets, BBs, metal splinters. _____

_____

□ Yes □ No Previous Surgeries? _____

_____

_____

□ Yes □ No Pacemaker, clips, valves, stimulator device, or dermal patch (with dates)?

_____

□ Yes □ No Have you had a reaction to any contrast (MRI, CT) or a history of iodine allergy? If yes, please describe: _____

□ Yes □ No Are you taking a blood thinner? _____

□ Yes □ No Do you have kidney disease, renal failure, or are you on dialysis?

□ Yes □ No Pregnant? Last menstrual period: _____

□ Yes □ No Breast Feeding?

Height: _____ Weight: _____

Patient Signature: _____ Date:_____