CAHABA VALLEY IMAGING

MRI SCAN DATA SHEET

NAME: _____ DATE: _____

BIRTH DATE: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

DO YOU HAVE ANY OF THE FOLLOWING:

(PLEASE CHECK)	NO	YES	EXPLAIN
PACEMAKER/DEFIBRILLATOR			
HEART SURGERY (ie: valve replacement)			TYPE: WHEN:
HEART STENT			WHEN:
RENAL (KIDNEY) DISORDER			TYPE:
CAROTID CLIPS			WHEN:
MECHANICAL/ELECTRICAL DEVICES. (ie: pain or insulin pump)			
EPIDERMAL PATCH (ie: pain patch)			TYPE: WHERE: DATE PATCH WAS APPLIED:
DENTURES/PARTIALS (with metal)			
SHRAPNEL/METAL IN BODY			TYPE: SURGERY DATE: WHERE:
COCHLEAR (EAR) IMPLANT OR HEARING AID			
METAL SHAVINGS IN EYE			
HEAD SURGERY (ie: shunt; aneurysmal clip)			TYPE: WHEN:
ANY SURGERY IN THE PAST 6 WEEKS			TYPE: WHEN:
CANCER			TYPE: WHEN:
PREGNANT/CHANCE OF PREGNANCY			
IS TODAY'S SCAN RELATED TO ANY INJURY?			TYPE: WHEN:

X_____

PATIENT'S OR LEGAL GUARDIAN'S SIGNATURE