PATIENT HISTORY AND SAFETY CHECKLIST

Patient Name: ____ Patient #: ___________________

D.O.B. _____________________Age: ____________ Sex: ______________ Weight: ________________

Referring Physician: ____

	YES	NO
Cardiac Pacemaker?	( )	( )
Intracranial Aneurysm Clips?	( )	( )
Cochlear (EAR) Implant?	( )	( )
Orbital Implant or Prosthesis?	( )	( )
Metal Fragments in Eye?	( )	( )
Heart Valve, Stents, Filter?	( )	( )
If yes, what year? ____		
Neurostimulators?	( )	( )
Infusion Pumps? (I.e. Insulin, Chemotherapy)	( )	( )
Medication Patch?	( )	( )
Dentures or Partial Plate?	( )	( )
Hearing Aids?	( )	( )
Previous Surgery?	( )	( )

If yes, please list:

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	YES	NO
Do you have Renal Disease?	( )	( )
FOR MEN ONLY: Penile Implant?	( )	( )
FOR WOMEN ONLY: Is there a possibility or pregnancy?	( )	( )
FOR WOMEN ONLY: Do you have an Intrauterine Device?	( )	( )
Previous Exams for Current Problem?	( )	( )

If yes, location and date? :____

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form. I consent to treatment as prescribed by my physician.

PATIENT SIGNATURE: ____

WITNESS: ____DATE:_____________________