HEAD EVALUATION

Last Name:	First:	Date:

THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY

1. Have you had an MRI or CT scan of this body part previously? Yes or No (circle one)
- If so, where and when?_____

2. Describe what made you go see your doctor: _____
_____
_____

3. Do you have headaches? Yes or No (Circle one) If yes, where are they located?_____
_____

4. Have you had seizures or other central nervous system deficit (stroke, fainting, etc.)? Yes or No (Circle one) If so, what type of CNS
deficit?_____

5. Have you had any changes in vision, speech, balance or thinking? Yes or No (Circle one) If so, describe:_____
_____

6. Do you have a history of cancer? Yes or No (Circle one) If yes, what
type?_____

Have you undergone cancer treatment(s)? Yes or No (Circle one) Type:_____

When did you have treatment(s) for cancer? _____

7. Have you had surgery to your head? Yes or No (Circle one)
When?_____

8. Do you have any other medical conditions? Yes or No (Circle one) If so,
list:_____
_____

9. Are you taking any medications? Yes or No (Circle one) If so,
list:_____
_____

10. Have you had any trauma to your head(e.g. car accident, fall)? Yes or No (Circle one)
When?_____

Please fill out back of this form

California Advanced Imaging – *Patient History, Safety Screening, and Consent Form*

- Have you ever had metal fragments in your eyes? Yes □ No □
- Do you have any metal fragments in your body? Yes □ No □
- Do you have any prostheses? What type? _____ Yes □ No □
- Have you ever had spine surgery? Date _____ Yes □ No □
- Have you ever had heart surgery? Date _____ Yes □ No □
- Do you have a **pacemaker** or **a cardiac defibrillator**? Yes □ No □
- Do you have a surgically implanted heart valve? Yes □ No □
- Have you ever had brain surgery? Date _____ Yes □ No □
- Do you have brain **(aneurysm)** clips? Yes □ No □
- Have you ever had middle or inner ear surgery? Date _____ Yes □ No □
- Have you ever had eye surgery? Date _____ Yes □ No □
- Do you have an **insulin or medication pump**? Yes □ No □
- Do you wear dentures? Yes □ No □
- Do you wear **hearing aids*?(Remove prior to MRI)*** Yes □ No □
- Do you have on you any magnetically activated device? Yes □ No □
- Do you have any transdermal (medication patches) on you? Yes □ No □
- Do you have permanent make-up (eyeliner, etc.)? Yes □ No □
- Have you or are you using a "pillcam"/M2A endoscopy capsule? Yes □ No □
- ***Females only:*** Is there a chance that you might be pregnant? Yes □ No □

Print Name _____**Age** _____ **Weight** _____

Patient signature _____ **Date** _____

Parent signature (if under 18 years old) _____

Only answer the following questions if you are receiving an IV contrast injection:

Have you ever had MRI contrast? Yes □ No □
Have you had any kind of reaction to contrast? Yes □ No □
If yes please explain: _____
Are you currently breast feeding? Yes □ No □
Are you diabetic? Yes □ No □
Do you have any history of hypertension (high blood pressure)? Yes □ No □
Do you have any history of kidney (renal) insufficiency or failure? Yes □ No □
Do you have a solitary kidney? Yes □ No □
Are you on dialysis? Yes □ No □
Do you have any liver disease? Yes □ No □
Have you had or going to have a liver transplant? Yes □ No □