GUILFORD RADIOLOGY

Imaging Excellence with Personalized Care

203.453.5123 • 1591 Boston Post Rd, Guilford, CT 06437
guilfordradiology.com

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

1.	Do you have a cardiac pacemaker?	Yes	No
2.	Do you have any aneurysm clips or coils in your head or neck?	Yes	No
3.	Have you EVER had HEART or BRAIN surgery? If yes, describe: _____	Yes	No
4.	Do you have any metallic, mechanical or electronic implants or foreign bodies anywhere in your body?	Yes	No
5.	If yes, describe: _____		
6.	Have you EVER had any eye or ear surgery? If yes, describe: _____	Yes	No
7.	Have you ever had a metal injury to your eye that penetrated? How was it removed? _____	Yes	No
8.	Have you ever had a surgical procedure to the body part that is being imaged?	Yes	No
9.	If yes, please list: _____		
10.	Have you had any of the following tests related to the body part we are screening today?		

- ☐ X-Rays Date of Scan: _____ Facility Name: _____
- ☐ CT Scan Date of Scan: _____ Facility Name: _____
- ☐ MRI Scan Date of Scan: _____ Facility Name: _____
- ☐ U/S Date of Scan: _____ Facility Name: _____

11.	Is there any chance you could be pregnant?	Yes	No
12.	Are you a nursing mother?	Yes	No
13.	Are you claustrophobic?	Yes	No
14.	Are you able to walk, stand and pivot without assistance?	Yes	No
15.	Do you have an allergy to MRI contrast?	Yes	No

The following items can interfere with MR imaging and some may be hazardous to your safety.
Please check the appropriate box for each of the following items:

Mechanical Heart Valve	Yes	No	Cochlear Implant	Yes	No
Neurostimulator	Yes	No	Surgical clips/staples/wires	Yes	No
Artificial joint	Yes	No	Stents	Yes	No
Bone plates/rods/screws	Yes	No	Ocular Implant (Eyes)	Yes	No
Shunt	Yes	No	Tattoos (past 30 days)	Yes	No
IUD	Yes	No	Colored Contact/Magnetic Lashes	Yes	No
Sports Clothing	Yes	No	Pain/Medication Patch	Yes	No
Compression Stocking	Yes	No	Bullets, BBs, Shrapnel	Yes	No
Body Piercings	Yes	No	**Any Other Implants of ANY kind**	Yes	No
Hearing Aids or Dentures	Yes	No	Details: _____		

I attest that the above information is true 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 this information.

Signature: _____ Relation to patient: _____

Technologist signature: _____ Date: _____