

McLAREN THUMB REGION - PATIENT HEALTH ASSESSMENT

IMAGING DEPARTMENT PHONE: (989) 269-8933 Ext. 4560 • FAX: (989) 269-5209

Name:		DOB:	DATE:
Exam Ordered:	Weight:	Physician Name:	
Some of the following items may be hazard correct answer to each of the following. Do		and may interfere with your MRI ex	xamination. Please check the
Cardiac pacemaker or defibrillator	Yes □ No □	Internal pacing wires	Yes □ No □
Surgical clips in head, neck, chest, abdomen	Yes □ No □	Insulin / infusion pump/pain	Yes □ No □
Implanted drug infusion device	Yes □ No □	Eye or ear implant	Yes □ No □
Bone growth / fusion stimulator	Yes □ No □	Shunt (spinal or head)	Yes □ No □
Bone treated with rods, pins, plates, screws	Yes □ No □	Metal fragments	Yes □ No □
Aneurysm clips, staples, wires	Yes □ No □	Metal wire / mesh	Yes □ No □
Stent, filter, coil, wire placement	Yes □ No □	Artificial limb / joint	Yes □ No □
Tattooed make-up (eye liner, lips, etc.)	Yes □ No □	Body piercings	Yes □ No □
Medication patch	Yes □ No □	Hearing aid	Yes □ No □
Dentures or partial plates	Yes □ No □	Claustrophobia	Yes □ No □
Chance of pregnancy	Yes □ No □	Seizures / diabetes / stroke	Yes □ No □
Nursing mother	Yes □ No □	Penile implants	Yes No
IUD or diaphragm	Yes □ No □	Tether	Yes No
Kidney disease	Yes □ No □	Breast tissue expander	Yes No
-	Yes □ No □	Heart valve replacement	Yes No
Hypertension	103 🗀 110 🗀	ricart valve replacement	
Hypertension HAVE YOU HAD ANY INJURY TO THE EYE IN SHRAPNEL, ETC.? Yes □ No □ (IF YE) Are you allergic to any medication? If so, p	S, PLEASE INFORM	THE MRITECHNOLOGIST BEFORE	COMPLETING THIS FORM.)
HAVE YOU HAD ANY INJURY TO THE EYE IN SHRAPNEL, ETC.? Yes □ No □ (IF YE	S, PLEASE INFORM	JCH AS METAL SHAVINGS, CARBO THE MRI TECHNOLOGIST BEFORE	N STEEL, GRINDING METAL, COMPLETING THIS FORM.)
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ADDRESSOGRAPH

Medication Guide Given ☐ Initials _