

PATIENT HISTORY & SAFETY SCREENING

LAST NAME	FIRST	MIDDLE INIT.	AGE	TODAY'S DATE

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

YES NO

- Cardiac Pacemaker
- Brain Vessel Clips
- Aortic Clips
- Artificial Heart Valve
- Coronary, Artery, or Heart Surgery, if yes, when? _____
- Insulin Pump
- Electrodes
- Tens Units or Pain Stimulating Unit
- Ear Surgery or Implants
- Hearing Aids
- Metal Fragments in the Head, Eye or Skin
- Have you ever worked with metal or as a metal worker?
- Any previous skull surgery
If yes, what was the surgery for? _____

- Is there any chance you are pregnant?
(Not recommended for women in their first trimester of pregnancy)

<p>Signature of Patient: _____</p> <p>Signature of Parent or Guardian: _____</p> <p>Date: _____</p>
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