

PATIENT AND VISITOR SCREENING INFORMATION

Name _____

Please answer the following questions:

- 1. Have you ever been a grinder, metal worker or welder?YES or NO
 had a foreign body in your eye?YES or NO
 If YES, was it metallic?YES or NO

- 2. What medications do you currently take?

- 3. Is there any chance that you may be pregnant?YES or NO
 Date of last menstrual period _____

- 4. Do you have a cardiac pacemaker?YES or NO
 an artificial heart valve?YES or NO
 an aneurysm clip?YES or NO
 shrapnel or bullet (s)?YES or NO
 IUD (female only)?YES or NO
 A neurostimulator?YES or NO
 other implanted devices?YES or NO

- 5. Are you a diabetic?YES or NO

- 6. Are you being treated for TB (tuberculosis)?YES or NO

- 7. Do you wear dentures, partials, retainers or braces?YES or NO
 a prosthetic device (limb, eye, joint, ear)?YES or NO

- 8. Have you had surgery on your: HeadYES or NO
 NeckYES or NO
 SpineYES or NO
 ChestYES or NO
 AbdomenYES or NO
 LimbsYES or NO
 OtherYES or NO

- 9. Are you being treated for any other medical problems?YES or NO
 Please specify _____

- 10. What is your present weight? _____

PLEASE REMOVE ALL JEWELRY, WATCHES, CREDIT CARDS, COINS AND METALLIC COSMETICS.

Signature _____