BEACON IMAGING CENTER **PATIENT HISTORY AND SAFETY SCREENING**

Please Complete Form in BLUE or BLACK ink ONLY!

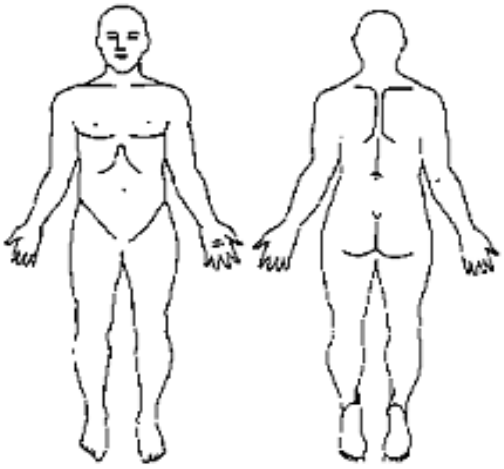
DATE _____ **Type of music or news to listen to** _____

PHONE _____

NAME _____ AGE _____ WEIGHT _____

DOB _____ MALE _____ FEMALE _____

BODY PART TO BE EXAMINED _____



Briefly describe current symptoms and when they first occurred:

List all MRIs and Xrays you have had on this body part:

WHEN WHERE

office use only-previous study ***REPORT*** ☐ ***IMAGES*** ☐

List any surgery you have had for this part of your body:

WHAT WHEN WHERE

Please shade in on diagrams all areas which are affected by your current problem.

The following items can interfere with the imaging and some may be hazardous to your safety.
PLEASE CIRCLE THE FOLLOWING:

Any Type of Implant?	Y	N	Are you Claustrophobic	Y	N
Pacemaker/Defibrillator/Heart Monitor	Y	N			
Brain/Aneurysm Clip/Shunt?	Y	N	Swan-Ganz Catheter?	Y	N
Implanted/Infusion/Insulin Pump?	Y	N	Vascular Access Port?	Y	N
Brain/Spinal Stimulator (Tens Unit)?	Y	N	Any Personal History of Cancer?	Y	N
Hearing Aid/Ear Implants?	Y	N	Type: _____		
Intraocular lens/Eyelid Spring/Artificial Eye	Y	N	Are you Diabetic?	Y	N
Heart Valve/Coil/Filter/Stent?	Y	N	Do you have Sickle Cell Anemia?	Y	N
Tattoo/Permanent Cosmetic/Magnetic lashes	Y	N	Kidney Disease/Failure/Transplant?	Y	N
Patch on Skin for Medication?	Y	N	Liver Disease/Hepatitis/Transplant?	Y	N
Any Rods, Screws, Pins in Bones?	Y	N	High Blood Pressure?	Y	N
Penile Implant?	Y	N	Any Blood Disorders?	Y	N
Artificial Joint/Limb?	Y	N	Allergies _____		
Have you ever been a Metal Worker?	Y	N	_____		
Have you been treated for Metal in the face or eyes?	Y	N	**For Women Only**		
Bullet/Shrapnel/Foreign body?	Y	N	Are you Pregnant?	Y	N
Dentures/Dental Implant?	Y	N	Are you Breast Feeding?	Y	N
Body Piercing?	Y	N	IUD or Diaphragm?	Y	N
Location of Body Piercing _____					

I am aware I will receive a bill for the RAD read by TriState IMG.

Signature of Patient _____

Signature of Parent or Guardian _____ Date _____