



SNI IMAGING

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PATIENT INFORMATION

Patient Name: _____ Date: _____

Patient SS#: _____ D.O.B. _____ Age: _____ Sex: M F

Weight: _____ Procedure _____

Clinical Information Diagnosis: _____

Previous CT or MRI? No Yes If yes, at which facility? _____

Have you taken any sedation/medication/alcohol today to relax you for this procedure? No Yes

If yes, explain: _____

DO YOU HAVE ANY OF THE FOLLOWING? *If yes, please explain.*

- Yes No Heart surgery/Heart valve/Pacemaker _____
- Yes No Brain surgery/Brain aneurysm clips _____
- Yes No Shunts/Stents/Intravascular coil _____
- Yes No Eye surgery/Implants _____
- Yes No Injury to eye involving metal or metal shavings _____
- Yes No Penile prosthesis _____
- Yes No Orthopedic pins, screws, rods, etc _____
- Yes No Neurostimulator/biostimulator _____
- Yes No Radiation therapy/chemotherapy _____
- Yes No History of cancer or tumors. _____
- Yes No Previous back surgery (neck/back) _____
- Yes No Ear surgery/cochlear implants/hearing aids _____
- Yes No Vascular access port _____
- Yes No Diaphragm/IUD/pessary _____
- Yes No Metal mesh implants/wire sutures/wire staples/internal electrodes _____
- Yes No Any electrical, mechanical, or magnetic implants _____
- Yes No Implanted cardiac defibrillator _____
- Yes No Pacing wires, Swann GANZ catheter _____
- Yes No Are you pregnant? Are you currently breastfeeding? _____
- Yes No Previous surgery: _____

Symptoms/Problems: _____

