Questionnaire

Please answer the following questions (Circle **Yes** or **No** to each question)

Does your child have any of the following?

1.	Cardiac pacemaker/defibillator	No / Yes
2.	Cardiac pacing wires	No / Yes
3.	Previous cardiac surgery	No / Yes
4.	Brain surgery	No / Yes
5.	Aneurysm clips	No / Yes
6.	Cochlear implant	No / Yes
7.	Bone growth stimulators	No / Yes
8.	Neurostimulators	No / Yes
9.	Implant drug infusion devices	No / Yes
10.	Metal fragments in eye	No / Yes

Extra questions for adolescents

11.	Are you pregnant or suspect your are pregnant?	No / Yes
12.	Do you have an I.U.D.	No / Yes

If you have answered yes to any of the above 11 questions, please ring 9345 5324.
There is no need to telephone concerning the following questions.

Does your child have any of the following?

13.	Brain shunt tube	No / Yes
14.	Hearing aid	No / Yes
15.	Joint replacement or prosthesis	No / Yes
16.	Metal pins, rods or screws in bone/soft tissue	No / Yes
17.	Shrapnel, bullet, gunshot	No / Yes
18.	Denture/teeth braces	No / Yes
19.	Any other implanted metallic device	No / Yes

20. Previous operations, if so, complete the following questions — No / Yes

a) what type of operation? ....

b) at which hospital? ....

c) what was the surgeon? ....

d) date of operation? ....

21. Any of the following procedures?

a)	MRI scan	No / Yes
b)	CT scan	No / Yes
c)	Ultrasound	No / Yes
d)	Other x-rays	No / Yes

To the best of my knowledge the above answers are true.

Patients Name: ....

Signature (Parent/Guardian)..

Date: ....

Office use only:

Checked by: MIT / RN / DR

Date: