PATIENT SAFETY QUESTIONAIRE

Please tick the appropriate box	YES	NO
Do you have a cardiac pacemaker, cardiac defibrillator or artificial heart valve?		
At any time in your life have you **EVER** had any metal go into your eyes? ***Details:***		
Do you have any metal fragments in your body? e.g. shrapnel		
Have you had any operations? ***Details:***		
Have you ever had any operations involving the use of metal implants e.g. joint replacements, clips, pins or coils? ***Details:***		
Have you ever had any type of electronic, mechanical or magnetic implant? ***Details:***		
Do you have any allergies or suffer from asthma? ***Details:***		
Do you have, or are you wearing any of the following?	YES	NO
Dentures		
Hearing aids		
Jewellery, including body piercing		
Tattoo		
Medicated patches e.g. nicotine, HRT		
False limb, caliper or brace		
Eye makeup		
Do you have any of the following conditions	YES	NO
Fits, blackouts or epilepsy		
Diabetes		
Heart/Kidney problems		
For women of child bearing age	YES	NO
Is there any possibility that you might be pregnant		
Are you breast feeding		

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