

PATIENT HISTORY



Patient label

Height: _____ Weight: _____

Reason for Study:

Have you had recent imaging procedures for these symptoms such as X-Ray, CT or MRI of the affected area? YES NO If YES, Please list date & location below.

Are you providing prior films or images on CD? YES NO

For Female Patients -

Is there a chance you are pregnant? YES NO Breastfeeding? YES NO

Date of last menstrual cycle: _____

Post menopausal or Hysterectomy YES NO

Would you like us to send a copy of your exam report to your Primary Care Physician? No Yes fax to Dr. _____

First and last name please

Check all that applies to you:

- | | | |
|---|---|--|
| <input type="checkbox"/> Lump or Mass, Biopsy | <input type="checkbox"/> Surgery | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Infection | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Injury or Accident | <input type="checkbox"/> Sports Related Injury |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Seizure | |

ALLERGIES: _____

Patient Signature _____ **Date** _____

Technologist Use Only

Tech _____ Date _____ Labs Needed? YES NO

IF yes Outside Labs dated _____ Sun Radiology Piccolo BUN ___ Creat ___
Contrast Type _____ How administered _____ Amount _____
Contrast Reaction? YES NO If Yes explain _____

Tech Notes

Tech Signature _____