Diagnostic Outpatient Imaging History Form

Date: ___________________________

Patient Name: _________________________________ DOB: ____________ Age: ______ Height:______ Weight:______

Referring Physician: ___________________________ Chemical Dependence? Yes___ No ___ Alcohol dependence? Yes___ No___

Tobacco use? (# of years)_______ Prior blood transfusion? Yes____ No____ Are you pregnant? Yes_____ No_____

Number of children__________ Last menstrual period___________________ Breast feeding? Yes____ No____

Have you ever had an MRI scan? Yes______ No______ Location? _________________________

Have you ever had a CT scan? Yes______ No______ Location? _________________________

Have you ever had an Ultrasound? Yes______ No______ Location? _________________________

Do you have a Heart Pacemaker? Yes____ No____ **Do you have a Brain Aneurysm Clip?** Yes_____ No_____

Surgeries

___Gallbladder ___Appendix ___Uterus (hysterectomy) ___Brain Others:_____________

___Tubal ligation ___Aortic Aneurysm ___Cervical spine ___Ovaries ___________________

___Prostate ___Sinus ___Hernia repair ___Lumbar spine ___________________

___Heart

Drug Allergies

___Gadolinium ___IV Contrast/ Iodine ___Sulfa drugs ___Penicillin Others:__________________________________

Conditions

___Thyroid problems ___Heart disease ___High cholesterol ___Inner ear tubes

___Kidney disease ___Mononucleosis ___Removable dentures ___Cochlear implant

___Sleep Apnea ___Multiple Sclerosis ___False eye/Ocular implants ___Porta cath

___Epilepsy ___Pneumonia ___Hearing Aid ___Brain Pacemaker

___Gout ___Ulcers ___Nerve or Bio Stimulators ___Eye Stents

___Emphysema ___Dialysis ___Orthopedic screws, rods or plates ___Penile implant

___Bronchitis ___Hernia ___Permanent eyeliner or tattoos ___Bladder stimulator

___Anemia ___AIDS ___I.U.D. ___Medication patches

___Tuberculosis ___Asthma ___Insulin Infusion Pump ___Pain/Nicotine patch

___Liver disease ___Diabetes (insulin) ___Bullets/BBs/Shrapnel ___Nitroglycerin patch

___High blood pressure ___Diabetes (Metformin) ___Vena Cava Filter ___Birth control patch

___Stroke ___Appendicitis ___Heart Valve/Stent Other, please specify:

___Dental Fillings ___Bleeding disorder ___Breast tissue expander _____________________

___Cancer (please specify): ___Goiter ___Breast biopsy clip _____________________

________________________ ___Hepatitis ___Cardiac monitor _____________________

Have your eyes been exposed to metal fragments? Yes____ No____

Do you have any implanted devices in your body? Yes____ No____

Do you have an artificial limb/prosthesis in your body? Yes ____ No____

Reason for exam(s)/symptoms ____

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****Due to strong magnetic field, the following items are prohibited within or near the MRI Scan Room: Firearms, Knives, Multi-tools.**

I verify that the information above is accurate to the best of my knowledge.______________________________________

***Patient signature**

TECH USE ONLY**

Oral sedation give: Xanax/Chloral Hydrate Time given__________________ Dosage:________________________

Reaction:____