diagnostichealth

Patient Information

*Date:*_____

Patient Name _____ Sex: ☐ M ☐ F Height:_____ Weight:_____

Patient ID#: _____ DOB:_____ Referring:_____

Procedure(s):_____

Reason you are here today for an exam?

Pain? Y N Swelling? Y N Bruising? Y N Lump? Y N

Location/notes:

Prior surgery to body part? Y N Prior Injections? Y N Injury? Y N _____

Have you had a previous imaging study related to this problem (x-ray, ultrasound, CT, MRI)? ☐ Yes ☐ No

What exam?_____ When?_____ Name of facility:_____

List Medical Conditions:_____

List Surgeries: _____

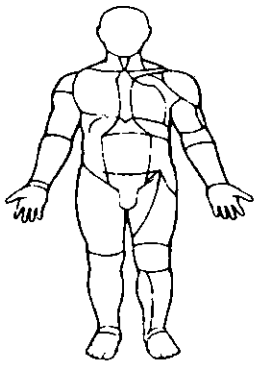
Do you take medications: ☐Yes ☐ No

ALLERGIES: List any drug, latex, or food allergies: _____

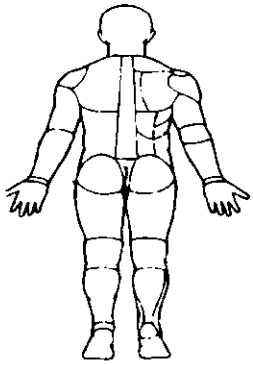
Do you Smoke? ☐Yes ☐ No If yes, # of years:_____ Packs per day:_____

Draw/Circle where your PAIN &/or Symptoms are located:

RT **Front** LT



LT **Back** RT



Are you pregnant? ☐Yes ☐No ☐N/A

Date of last period: _____

(Tech use only: Patient Shielded? ☐Yes ☐No)

Acknowledgement: I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that I am not pregnant at this time. I give consent to the performance of the exam requested by my physician at Diagnostic Health, Reading.

_____ _____ _____

Patient / Guardian Signature **Technologist / Witness Signature** **Date**

diagnostichealth

** ***FOR MRI ONLY*** **

WARNING: It is very important that you inform the technologist if you have a heart valve, a pacemaker, aneurysm clips or any other implanted items in your body. Certain implants and devices may be hazardous to you and/or may interfere with the MRI procedure. The MRI system is always on.

Do you have any of the following?

☐ Yes ☐ No Heart Surgery (Heart Valve, Pacemaker, Cardiac Defibrillator, Pacing wires. Explain:_____

☐ Yes ☐ No Brain Surgery; Brain Aneurysm Clips. If yes, explain:_____

☐ Yes ☐ No Shunts /Stents /Intravascular Coil. If yes, explain:_____

☐ Yes ☐ No Injury to eye involving metal or metal shavings. If yes, explain:_____

☐ Yes ☐ No Eye Surgery (Powered Eye/Artificial). If yes, explain:_____

☐ Yes ☐ No Hearing Aids : **If Yes – you MUST remove them.**

☐ Yes ☐ No Ear Surgery / Cochlear Implants. If yes, explain:_____

☐ Yes ☐ No Penile Prosthesis. If yes, explain:_____

☐ Yes ☐ No Orthopedic pins, screws, rods, etc. If yes, explain:_____

☐ Yes ☐ No Neurostimulator / Biostimulator. If yes, explain:_____

☐ Yes ☐ No History of Cancer or Tumors. If yes, explain:_____

☐ Yes ☐ No Radiation Therapy/Chemo Therapy. If yes, explain:_____

☐ Yes ☐ No Previous back surgery (neck/back). If yes, explain:_____

☐ Yes ☐ No Any electrical, mechanical, or magnetic implants. If yes, type:_____

☐ Yes ☐ No Implanted drug infusion pump/insulin pump. If yes, explain:_____

☐ Yes ☐ No Tattoos/Permanent make-up/Body piercings. If yes, explain:_____

☐ Yes ☐ No Gunshot wounds, shrapnel, BBs. If yes, explain:_____

☐ Yes ☐ No Medication Patch. If yes, explain:_____

☐ Yes ☐ No Dentures / Partials. If yes, explain:_____

MRI: Your physician has requested that we perform a magnetic resonance imaging (MRI) examination to obtain additional information. MRI uses a magnetic field and radio waves to produce an image of the internal body parts being examined. MRI is painless, and does not use x-rays or radiation. The only discomfort involved maybe having to lie quietly in a confined space during the study. Because MRI is a diagnostic procedure, it provides information that may aid your physician in diagnosing and treating your medical condition. Without the MRI scan, accurate diagnosis and proper treatment may be delayed.

If you are pregnant or think that you may be pregnant, please inform the center personnel at once.