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# PATIENT INFORMATION

Today’s Date: Chart Number:\_

Patient Name: DOB: Height: Weight:

The cause of your visit with us today? Date of Injury:\_\_

**(circle one)** Vehicle Incident: Yes No

# What other imaging studies have you had recently?

Date:\_ Type of Exam: \_ Place: Results: Date:\_ Type of Exam: \_ Place: Results: Date:\_ Type of Exam: \_ Place: Results: Are you taking Metformin Hydrochloride (Glucophage, Glucovance, Avandament, Metaglip)?

BUN

Creatine

N/A \_ Last Drawn\_\_

Have you taken anything for anxiety or claustrophobia today? Yes No

If yes, What medication:\_ Dosage/Mg: \_\_

# (Female Patients Only)

**Pregnancy Disclosure**:

Patients Name: \_ DOB:

Referring Physician: Date:

1. Is it possible that you might be pregnant at this time? Y/N
2. Date of last pregnancy test \_Results\_
3. Have you had a tubal ligation or hysterectomy? Y/N

If so when? \_

1. Last menstrual period?
2. Do you have an IUD? Y/N If yes which type

I \_\_ \_ give consent for an \_ procedure. I have been counseled regarding risks in reference to radioactive exposure during this elective procedure. You may be required to take a pregnancy test prior to an exam.

Patient Signature: \_ \_ Patient Print: \_\_ \_ Witness: \_

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