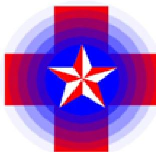

PATIENT INFORMATION

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? ____

4. Last menstrual period? ____
5. 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: ____