Diagnostic Outpatient Imaging History Form

Date_____

Patient Name_____ DOB_____ Age_____
Weight_____
Referring Physician_____ Alcohol dependence? Yes_____
No_____
Tobacco use? (#of years)_____ Prior blood transfusion? Yes____ No____ Are you pregnant
Yes_____ No_____Number of children_____ Last menstrual period_____

Have you ever had an MRI scan? Yes_____ No_____ Facility?_____
Have you ever had a CT scan? Yes_____ No_____ Facility?_____
Have you ever had an Ultrasound? Yes_____ No_____ Facility?_____

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

___Removable dentures ___Epilepsy ___Heart disease ___Appendicitis
___False eye/ocular implants ___Gout ___Mononucleosis ___Bleeding disorder
___Hearing Aid ___Emphysema ___Multiple Sclerosis
___Chemical
___Nerve or Bio Stimulators ___Bronchitis ___Pneumonia dependency
___Orthopedic screws, rods or plates ___Anemia ___Ulcers
___Claustrophobia
___Permanent eyeliner or tattoos ___Tuberculosis ___Dialysis ___Goiter
___I.U.D. ___Liver disease ___Hernia ___Hepatitis
___Insulin Infusion Pump ___High blood pressure ___AIDS ___High cholesterol
___Bullets/BBs/Shrapnel ___Stroke ___Asthma ___Inner ear tubes/
___Thyroid problems ___Cancer (please specify) ___Diabetes (Glucophage) cochlear implant
___Kidney disease _____ ___Diabetes (Metformin) ___PortaCath
___Vena Cava Filter ___Dental fillings ___Claustrophobia ___Hernia
___Sleep Apnea
Others_____

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)/symtoms_____
_____
_____
_____
_____

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:_____
_____