PATIENT MEDICAL HISTORY

Do you, the patient, have a personal history of – (please circle)

Yes No Cancer Type______________________Date____________________
Yes No Kidney disease/dialysis Type______________________Date____________________
Yes No High Blood Pressure/Cardiac disease
Yes No Diabetic
Yes No Seizure Describe____________________________Date of last one_______________
Yes No Stroke Describe____________________________Date of stroke________________
Yes No Allergy/Asthma Describe____
List any other medical conditions ____

Have you ever had another test of the area that is being scanned today?

			Body area	Location/Facility	Date
Yes	No	X-ray	____________________	__________________________	_____________
Yes	No	MRI	____________________	__________________________	_____________
Yes	No	CT	____________________	__________________________	_____________
Yes	No	Nuc Med	________________	__________________________	_____________
Yes	No	Ultrasound	________________	__________________________	_____________
Yes	No	Mammogram/Thermogram		__________________________	_____________
Yes	No	Echo (Cardiac MRI Patients only)		__________________________	_____________

What is your main complaint or reason your doctor ordered your test today?
____
____

How long have you had this complaint/symptom? (please give an approximate timeframe for each symptom)
____
____

Are your symptoms: ________Improving Describe____
________Getting Worse Describe____
________About the Same Describe____

Yes No Did you sustain an injury to the area to be scanned? If yes, please describe____________________
____

Yes No Do you have a limited range of motion? If yes, please describe_______________________________
____

Yes No Do you have any swelling? If yes, please describe____
____

Yes No Do you have any discoloration? If yes, please describe_____________________________________
____

Yes No Do you have any numbness/tingling? If yes, please describe_________________________________
____

Yes No Do you have any weakness? If yes, please describe____
____

Yes No Have you had any surgery to the area being scanned today? If yes, please describe and include an approximate date____
____

Signature____D.O.B._______________Date__________