Patient Medical History

children's health℠ Imaging Center

Patient Name: _____ **Date of Birth**: _____
Referring Physician: _____ **Appointment Date**: _____

Explain the patient's medical problems that are the reason for having this diagnostic exam _____
_____

How long has the problem existed? _____

Has there been a recent injury/trauma to this area? _____
_____

Has the patient had prior imaging studies on the area being examined? If so, what type of scan and date(s) of scan?
_____

List all previous surgeries and dates of surgery _____
_____

Has the patient had any previous physical/conservative therapy? _____

Does the patient have a follow up appointment with the referring physician, if so, when? _____

Does the patient have any of the following?

□ Yes	□ No	Diabetes	□ Yes	□ No	Kidney Failure	□ Yes	□ No	Renal Disea
□ Yes	□ No	Renal Surgery	□ Yes	□ No	Multiple Myeloma	□ Yes	□ No	Cancer
□ Yes	□ No	Chemotherapy or Radiation	□ Yes	□ No	Heart Block	□ Yes	□ No	Heart Attack
□ Yes	□ No	Ventricular Tachycardia	□ Yes	□ No	Heart Disease	□ Yes	□ No	High Blood
□ Yes	□ No	Sino Arterial Dysfunction	□ Yes	□ No	Headaches	□ Yes	□ No	Seizures
□ Yes	□ No	Memory Loss	□ Yes	□ No	Asthma/Hay Fever	□ Yes	□ No	Severe Debi
□ Yes	□ No	HIV/Hepatitis	□ Yes	□ No	Sickle Cell Anemia	□ Yes	□ No	Dizziness
□ Yes	□ No	Hearing Loss □ Right □ Left						
□ Yes	□ No	Pain/Numbness/Weakness in Upper Extremity	□ Right	□ Left				
□ Yes	□ No	Pain/Numbness/Weakness in Lower Extremity	□ Right	□ Left				

MRI/CT ONLY: Does the patient have any of the following items in his/her body?

□ Yes	□ No	Pacemaker/Wires/Defibrillator	□ Yes	□ No	Body Piercing
□ Yes	□ No	Brain Aneurysm Clip	□ Yes	□ No	Ear Implant
□ Yes	□ No	Eye Implant	□ Yes	□ No	Electrical Nerve Stimulator
□ Yes	□ No	Bullets/BBs/Pellets	□ Yes	□ No	Metal Implants
□ Yes	□ No	Coil/Filter/Stents in Blood Vessels	□ Yes	□ No	Artificial Limb/Joint
□ Yes	□ No	Permanent Tattoos	□ Yes	□ No	Implanted Catheter/Tube
□ Yes	□ No	Artificial Heart Valve	□ Yes	□ No	Penile Prosthesis
□ Yes	□ No	Shunt	□ Yes	□ No	False Teeth/Retainer/Magnetic Braces
□ Yes	□ No	Surgical Clips/Staples/Wires/Mesh/Stitches	□ Yes	□ No	Diaphragm/Intrauterine Devices
□ Yes	□ No	Plates/Screws/Pins/Rods	□ Yes	□ No	Bone Growth/Fusion Stimulator/Tissue Expander
□ Yes	□ No	Drug Infusion Pump	□ Yes	□ No	Hearing Aid
□ Yes	□ No	Metal in Eyes-If so, has the metal been removed by a doctor?			

****ALL Female Patients must answer the following questions****

Has the patient started her menstrual cycle? Yes No

If YES, when was the First Day of her Last menstrual cycle? / /

If YES, has the patient had intercourse since the first day of her last menstrual cycle? Yes No

If YES, is the patient using birth control (excluding condom)? _____

I authorize Children's Health Imaging to perform all diagnostic procedures that were ordered for me by my physician. I hereby release Children's Health Imaging from any and all liability pertaining to the performance of diagnostic imaging procedures. Furthermore, I understand and agree that Children's Health Imaging is released from all liability and litigation pertaining to myself, and/or my unborn child. I have been informed of the current risks to myself and to my unborn child (if pregnant) if exposed to radiation from a CT scan, X-Ray and/or IV & Oral contrast. While it is currently accepted that ultrasound and MRI are not proven to be harmful to an unborn child, if complications arise, I fully understand and agree to release Children's Health Imaging from any and all liabilities.

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

_____ _____/_____/_____

Signature of Parent/Guardian Date

_____ _____

Print Name (Parent/Guardian) Relationship to patient