PATIENT HISTORY QUESTIONNAIRE

PATIENT'S NAME: _____

DOB: _____ **AGE:** _____ **WEIGHT:** _____

SIGNATURE: _____ **DATE:** _____

Describe your symptoms or the reason for this study in detail.

_____

_____

How long have you had this condition, symptoms or injury (insurance requires a complete date i.e month, day, year)?

Injury date _____ If this is chronic pain, how long have you had your pain? _____

Specify the date of increase pain or new symptoms _____

List previous surgeries: _____

_____

List all medications you are currently taking: _____

Please answer the following questions:

- ❑ Have you ever had a reaction to a contrast medium?
- ❑ Aneurysm clips
- ❑ History of kidney problems
- ❑ History of high blood pressure
- ❑ Any medical implants of devices (metal or other)?
- ❑ Pacemaker
- ❑ Stents, artificial heart valve
- ❑ History of asthma
- ❑ History of Sickle Cell disease
- ❑ Any transdermal patches (nitro/nicotine, etc)?
- ❑ Do you work with metal or has any metal been removed from your eyes? _____
- ❑ Have you ever been wounded by a gun shot? If so, was the bullet removed? _____
- ❑ Any personal history of cancer? If yes, what type? _____
- ❑ Are your symptoms injury related? If yes, how did injury occur? _____
- ❑ Were you injured in an automobile accident? If yes, what date? _____
- ❑ Were you injured at work? If yes, what date? _____
- ❑ Are you pregnant or breast feeding?
- ❑ Have you had any previous diagnostic studies? If yes, what and where? _____