

PATIENT INFORMATION

Fall Precaution YES NO

Last Name	First Name/Middle Initial	Gender	Race
Date of Birth (MM/DD/YYYY) / /	Age	Height	Weight

PERSONAL HISTORY

Have you had a previous imaging study related to this problem? Yes No

If yes, What exam? CT MRI Ultrasound X-ray Other

What Facility? _____

FEMALE PATIENTS ONLY

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

Are you breastfeeding YES NO **Date of last period:** _____

ACKNOWLEDGMENT

I have answered these questions to the best of my knowledge and understand the information presented to me. If I am to have intravenous contrast with my procedure, I have been informed of the risks.

PARENT/ GAURADIAN SIGNATURE

DATE

TECHNOLOGIST SIGNATURE

DATE