

ACCT. # _____

NAME _____ SEX _____ HEIGHT _____ WEIGHT _____ DATE _____

DOB _____ AGE _____ REFERRING DR. _____ DATE OF NEXT APPT. _____

EMERGENCY CONTACT _____ PHONE _____ RELATION _____

FEMALE PATIENTS: PREGNANT? YES NO (circle one) LAST MENSTRUAL PERIOD? _____
HYSTERECTOMY? YES NO (circle one) IF YES, WHEN? _____

DESCRIBE CURRENT COMPLAINTS/SYMPTOMS: _____

LIST SURGERY(S), INCLUDE BODY PART AND DATE: _____

LIST PRIOR EXAM(S) RELATED TO TODAY'S STUDY: LIST LOCATION OF EXAM(S): _____

LIST ALL ALLERGIES: _____

- | | | | |
|---|------------------------------------|-------------------------------------|---------------------|
| PLEASE CIRCLE IF APPLIES TO YOU: | Myasthenia Gravis | Intrauterine Device (IUD) | Sickle Cell Disease |
| Allergies to Iodine/Shellfish | Multiple Myeloma | Implants: Eye, Ear, Penile | Hypertension |
| Cardiac Pacemaker | Myoglobinuria/Myoglobinemia | Metal Shrapnel or Fragments | Asthma |
| Brain Aneurysm Clip | Use Wheelchair/Stretcher | History of Cancer; Type _____ | Nursing Mother |
| Pheochromocytoma | Diabetic | Lupus Erythematosus | Metal in Eyes |
| Renal Disease/Kidney Removed | Take Diabetic Medications(s) | Paroxysmal Nocturnal Hemoglobinuria | Infusion Pump |
| Electrical Stimulator for Nerve/Bone | Have Tattoo/Permanent make up | Currently on Oxygen | Multiple Sclerosis |
| Dehydration/Poor Physical Condition | Coil, Filter, Wire in Blood Vessel | Artificial Limb/ Joint | |

ALL MRI, CT & IVP PATIENTS: Your doctor may request IV (intravenous) injection of contrast material for today's exam. Gadolinium is used for MRI exams and an iodine-based material is used for CT & IVP exams. These contrast materials may help diagnose a problem, but **will not** cure your condition. Complications from IV contrast are rare but can include, and are not limited to: nausea, vomiting, hives or rash. In extremely rare cases, kidney failure, difficulty breathing or even death, may occur.

I have read this form and answered the questions to the best of my knowledge. I hereby request and authorize performance of today's exam(s). I authorize Drew Medical, Inc. to release any films and/or reports necessary for evaluation of today's exam(s).

Patient Signature (or Legal Guardian) _____ Date _____

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

EXAM 1 _____	EXAM 2 _____	EXAM 3 _____	EXAM 4 _____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CONTRAST NAME/AMOUNT _____

COMMENTS _____

- EXAM INFORMATION**
- NO PRIOR EXAMS
 - PRIOR REPORTS ATTACHED
 - RESTORED PRIOR (S) TO PACS
 - DIGITIZED OSF TO PACS
 - COMPARISON REQUESTED
 - PRIOR FILMS NOT AVAILABLE
 - PRIOR REPORTS NOT AVAILABLE
 - FILMS W/PATIENT
 - FILMS TO PHYSICIAN
- DATES OF PRIOR EXAMS: _____

TECHNOLOGIST: _____

