CITY WIDE HEALTH FACILITY, INC.
RADIOLOGY DEPARTMENT
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SYMPTOMS – Please fill out this form as accurately and completely as possible

Patient's Name_____ **Date**_____

Age _____ **[ ] Male [ ] Female** **Today's Exam**_____

Symptom(s):_____

How long have you had this symptom(s)?_____

ARE YOU ALLERGIC TO LATEX? [ ] YES OR [ ] NO

ONLY FOR BONE DEXA SCAN TEST PATIENTS

What is your height? _____ **What is your Weight?**_____

At what age did you get your first (1st) Menstrual?_____ **Date or Age of your last Menstrual?** _____

Do you have Hyper Thyrodism? [ ] Yes [ ] No **Pathology of Fracture in past? [ ] Yes [ ] No**

CIRCLE ONLY ONE ANSWER. IF YOU ARE NOT SURE PLEASE ASK US TO ASSIST YOU.

Are you PREGNANT? YES or NO
Do you have ASTHMA? YES or NO
Are you DIABETIC? YES or NO If YES, are you taking GLUCOPHAGE? YES or NO
Do have any other medical problems? YES or NO If yes, explain:_____
Are you allergic to any medication? YES or NO If yes, which?:_____
Have you ever had any other radiology studies performed within the past 5 years? YES or NO
If yes, please list them_____
Have you had surgery within the past 5 years? YES or NO
If yes, please list them_____

MRI PATIENTS MUST ANSWER ALL OF THE QUESTIONS BELOW

DO YOU HAVE ANY OF THE FOLLOWING IN YOUR BODY: (ANSWER ONLY ONE – YES OR NO)

DO YOU HAVE A PACEMAKER? YES OR NO

ANEURYSM CLIPS	YES NO	MIDDLE EAR PROSTHESIS	YES NO
ARTIFICIAL HEART VALVES	YES NO	NEUROSTIMULATORS	YES NO
METAL FRAGMENTS	YES NO	BIOSTIMULATORS	YES NO
ITRACRANIAL CLIPS	YES NO	JOINT PROSTHESIS OR PIN	YES NO
CRANIAL PLATES	YES NO	HEARING AID	YES NO
METAL CLIPS	YES NO	REMOVABLE DENTURES	YES NO

IF YOU CIRCLED YES TO ANY OF THE ABOVE, PLEASE TELL THE TECHNICIAN BEFORE ENTERING THE MRI ROOM!!!

SIGNATURE: _____ **DATE:**_____

[ ] PATIENT [ ] GUARDIAN: LIST RELATIONSHIP _____