



ATLANTIC RADIOLOGY IMAGING, P.C.

"THE NEW IMAGING REALITY"

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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 Thyroidism? [] 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
INTRACRANIAL 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 _____