Riverwoods Imaging Center – 3152 N University Ave. Suite 200 – Provo, UT 84604, 801-229-1009, 801-229-1003 Fax

PATIENT HISTORY FORM

Name _____ Height _____ Weight _____

Birth Date _____ Age _____ Physician's Name _____

Briefly describe the physical symptoms you are experiencing or the reason for the exam _____

_____

_____

How long have you had this problem? _____
Have you had any previous studies? YES _____ NO _____ *(If YES, please list)*

MODALITY	*BODY PART*	*DATE*	*FACILITY / LOCATION*
MRI			
CT/CAT SCAN			
X-RAY			

Are you pregnant or experiencing a late menstrual period? YES _____ NO _____
Date of last menstrual period _____ Are you breast feeding? YES _____ NO _____

Have you ever had a reaction to the contrast media or dye used for MRI's or CT's examination?
YES _____ NO _____ If yes, please describe: _____

Do you have a personal history of cancer? YES _____ NO _____
If yes, what type of cancer was/is it? _____

Have you been diagnosed, or are you being treated for any medical conditions or illnesses? YES _____ NO _____
If yes, give a brief explanation: _____

YOUR DOCTOR WILL RECEIVE A COPY OF THE RESULTS OF TODAY'S STUDY WITHIN A FEW DAYS

Normally, the MRI scan is considered very safe. However, patients patients with certain implants and foreign bodies may experience some problems. **It is important for you to alert the technologist if there is any foreign material in your body**.

On some examinations it is necessary to inject a contrast material into your body. It is injected throught an IV that may be placed in your arm or hand. Normally, this contrast media is very safe. However, any injection or medication carries with it risks. These risks may include problems from the IV or in the form of a reaction to the contrast. The physicians and staff of the diagnostic imaging department are trained to treat these reactions. Do you consent to having the contrast injected if necessary? YES _____ NO _____

We are only able to scan the body part that your doctor has ordered. Do you consent to having the physician-ordered scan, and to changing into metal-free clothing prior to the exam? YES _____ NO _____

PLEASE COMPLETE AND SIGN THE NEXT PAGE

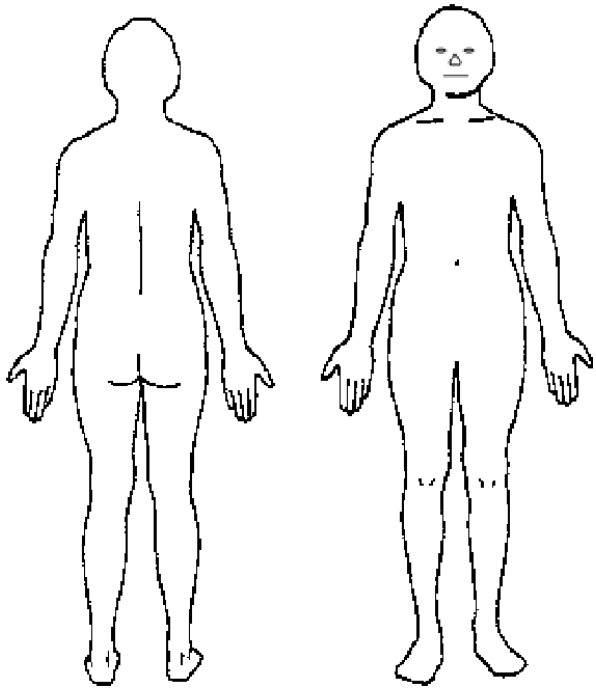
Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check and correct answer for the following:

Do you have any of the following?

YES	NO	ITEM or CONDITION
		Implanted Cardiac Defibrillator
		Aneurysm Clip(s)
		Neurostimulator
		Insulin or Infusion Pump
		Implanted Drug Infusion Device
		Bone Growth/Fusion Stimulator
		Cochlear, Otologic, or Ear Implant
		Any Type of Prosthesis (Eye, Penile, etc.)
		Heart Valve Prosthesis
		Artificial Limb or Joint
		Electrodes (on Body, Head, or Brain)
		Intravascular Stents, Filters, Coils
		Shunt (Spinal or Intraventricular)
		Vascular Access Port and/or Catheter
		Swan-Ganz Catheter
		Any Implant Held in Place By a Magnet
		Transdermal Delivery System (Nitro)
		IUD or Diaphragm
		Tattooed Makeup (Eyeliner, Lips, etc.)
		Body Piercing(s)
		Any Metal Fragments
		Internal Pacing Wires
		Aortic Clip
		Metal or Wire Mesh Implants
		Wire Sutures or Surgical Staples
		Harrington Rods (Spine)
		Metal Rods in Bones
		Joint Replacement:_____
		Bone/Joint Pin, Screw, Nail, Wire, Plate
		Hearing Aid (Remove Before MRI)
		Dentures (Remove Before MRI)
		Any Injury to the Eye Involving a Metallic Object?

Please mark on the figure below, the location of any implant or metal inside of or on your body.

BACK FRONT



Before your MRI, please remove all metallic objects including keys, hair pins, barrettes, jewelry, body piercing, bra, watch, safety pins, paperclips, money clips, credit cards, coins, pens, belt, metal buttons, pocketknife, and clothing with metal in the material.

OTHER, please explain: _____

NOTE: YOU ARE REQUIRED TO WEAR EARPLUGS OR EARPHONES DURING THE EXAM

Patient's Name: _____ Date _____

Signature of person completing form _____

Form completed by: PATIENT _____ RELATIVE _____
Name & Relationship to patient

OTHER _____
Name & Relationship to patient

Riverwoods

Please print out the complete 3-page form and Email it back to: RiverwoodsImaging2@yahoo.com or FAX it to (801) 229-1003, or Bring it with you to your appointment.

(PLEASE PRINT)

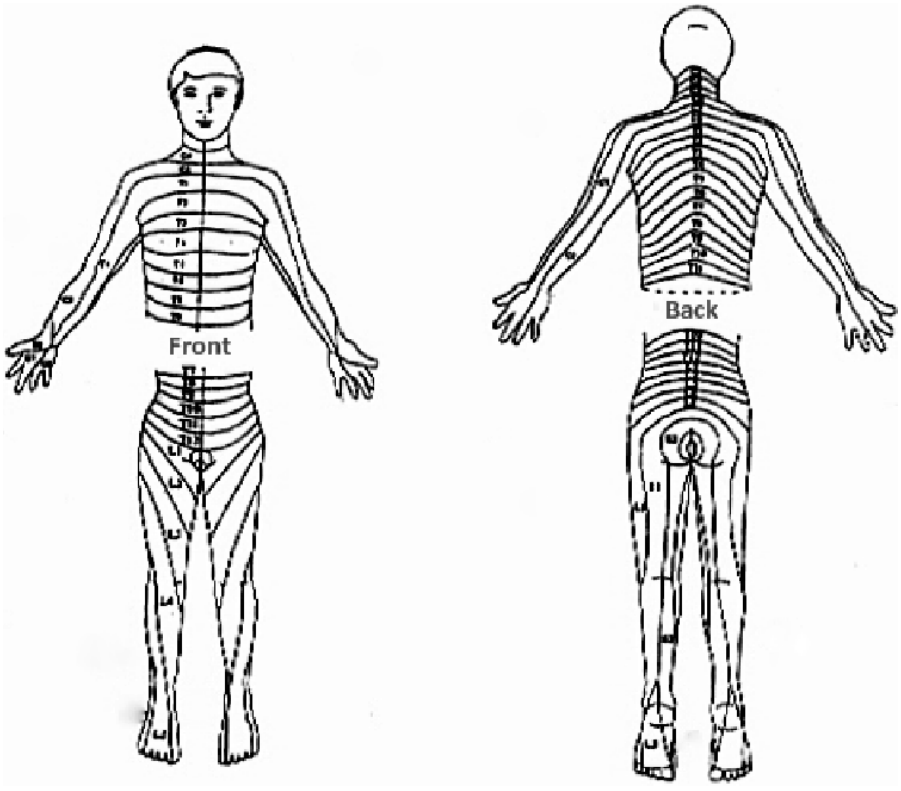
1. Patient's Name _____ Date _____
2. Referring Physician _____
3. Have you had an MRI or CT/CAT scan on the part of your body in which the procedure is to be performed? YES _____ NO _____
4. At which facility was your MRI or CT performed? _____
5. What is the level of intensity of your pain at this time on a scale of 0 to 10, with 0 being no pain and 10 being the greatest pain*? (Please circle the appropriate number.)*

0	1	2	3	4	5	6	7	8	9	10

6. Have you had surgery on the part of your body being scanned for this visit? YES _____ NO _____
7. If you did have surgery, when was this surgery performed? _____
8. Describe the location of your pain: _____

_____

SHADE IN THE AREA OF PAIN, NUMBNESS, and/or TINGLING



LEVEL OF PAIN AT DISCHARGE: (0 = no pain, 10 = extreme pain)

0	1	2	3	4	5	6	7	8	9	10