RAI PATIENT HISTORY CT EXTREMITY: **Today's Date:**_____

Name: _____Age: _____Weight:_____ Height: _____Referring Physician:_____

1. What part of the body are we scanning today:_____

2 .Describe your current problems/symptoms:_____

_____

A. Length of symptoms:_____ B. Location (Please circle which apply) INNER – OUTER - FRONT - BACK

3. Any surgery, arthroscopy, joint replacement or hardware on area being scanned? Circle Y – N

Type? _____ When? _____

4. Have you had an injections in this part of your body? Y - N When? _____ Type/Location?_____

5. If Injury/Accident/MVA –

a. Exact Location (ex. Muscle, bone): _____

b. Type of Injury/Symptoms (Circle One): 1. Abrasion 2. Contusion 3. Laceration/Open Wound 4. Penetrating 5. Sprain

6. Foreign Body 7. Swelling 8. Other_____

c. Which side of your body? (Circle One): Right Left Bilateral (Right and Left)

6. Describe any existing medical conditions (high blood pressure, diabetes):

_____

7. Do you have a history of cancer? Circle: Y - N Type? _____

8. Treatments related to cancer:

Chemo – if yes, date of last treatment_____ provide date of any future treatments planned _____

Radiation – if yes, date of last treatment_____ provide date of any future treatments planned _____

Other treatment – please describe and provide dates: _____

9. List ALL current medications: _____

10. Do you have any known allergies:_____

11. <u>Prior Diagnostic Imaging: Extremity Studies (XRAY/MR/CT):</u>

Study/Date/Facility:_____

_____

12. Has your physician prescribed any sedation or medication specifically for this examination? Yes - No

If yes, please indicate drug type and amount_____

13. FOR FEMALE PATIENTS:

1. Date of last menstrual period: _____ Post-menopausal? Yes - No (Circle which apply)
2. Are you pregnant or experiencing a late menstrual period?_____ Yes - No

I recognize that if I am pregnant and have radiation to the abdomen/pelvis there is a possibility of injury to the fetus. However, I understand that the likelihood of such injury is slight and that my physician feels that the information to be gained from this exam is important to my health. I, therefore, wish to have this exam performed now.

Signature_____ Date:_____

I attest that the answers I have provided to the questions on his form are correct to the best of my knowledge.

Patient signature:_____ Date: _____

Parent or Guardian signature:_____Relationship: _____ Date:_____

Technologist signature: _____ Date:_____

Comments:_____

_____

_____

_____Tech/TechAide initials_____