

First Name _____ Last Name _____ DOB/Age _____
 Ht. _____ Wt. _____ Allergies _____ PT# (Internal) _____

REASON FOR EXAM (Please include symptoms and time frame):

TECH NOTES (for internal use only):
IV Access:
 Contrast: _____ ml from _____ ml bottle
 Concentration: _____ mg/mol
 Guerbet Optiray GE Omnipaque
Additional Notes:

Previous Imaging Studies Related to Todays Exam	Date
Previous Surgeries Related to Todays Exam	Date

Is your area of concern related to an injury? Yes No If yes, continue:
 Date of Injury _____ How were you injured? Car Accident Work Other
 Describe Injury (please be specific) _____

Have you ever been diagnosed with Diabetes? Yes No If yes, medication? Oral Injection _____
 Have you ever had Renal Failure? Yes No If yes, when? _____
 Have you had kidney surgery or do you have only one kidney? Yes No If yes, which kidney? Right Left
 Have you ever been diagnosed with Cancer? Yes No If yes, what type? _____
 Location: _____ Has it spread? Yes No If yes, Where: _____
 Treatment: Surgery Radiation Chemo Other Cancer treatment(s): _____
 Date of Last Treatment: _____ Current status: Newly Diagnosed Remission Recurrence

Are you currently experiencing or have you ever experienced any of the following?

HEAD		How long? (ex: 1 month) or when? (ex: Aug, 2020)	SINUS		How long? (ex: 1 month) or when? (ex: Aug, 2020)
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No		Sinus Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Memory Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No		Facial Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tremor	<input type="checkbox"/> Yes <input type="checkbox"/> No		Congestion/Runny Nose	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No		Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No		Toothaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	
MS Diagnosis	<input type="checkbox"/> Yes <input type="checkbox"/> No		Post Nasal Drip	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hemorrhage	<input type="checkbox"/> Yes <input type="checkbox"/> No		Chronic Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No		Nose Bleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No		Deviated Septum	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Vision Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No		Snoring/Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No		Sinus Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	

I agree that the above information is correct (Do not fill out until after technologist has reviewed):
 Patient Signature: _____ Todays Date: _____