

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):
 Pre-operation exam Yes No
Additional Tech 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 below:
 Date of Injury _____ How were you injured? Car Accident Work Other
 Describe Injury (please be specific) _____

Are you experiencing pain? Yes No (if yes, continue below)
 Where? _____ How long? _____
 Describe your pain: Sharp Dull Other (please describe): _____

 Are you a Smoker? Current Past Never Current or past, do/did you smoke cigarettes Yes Other
 If other, please specify: _____ How many years? _____

Have you ever been diagnosed with Cancer? Yes No (if yes, continue below)
 What type of Cancer? _____ Location: _____ Date Diagnosed: _____
 Current status: Recurrence Remission Newly Diagnosed
 Treatment: Surgery Radiation Chemo Other Cancer Treatment(s): _____
 Has it spread? Yes No If yes, Where: _____
 Is your visit today related to this Cancer diagnosis? Yes No

Other important medical conditions: _____

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