

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

REASON FOR EXAM (Please include symptoms and time frame):
 (e.g. Pain or Pre-op exam for joint replacement, labrum/rotator cuff repair, etc.)

TECH NOTES (for internal use only):

Previous Imaging Studies Related to Todays Exam	Date

Previous Surgeries Related to Todays Exam	Date

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

Type of Procedure (check appropriate examination)

- Arthrogram Shoulder Arthrogram Hip Arthrogram Knee
- Arthrogram Elbow Arthrogram Iliopsoas Arthrogram Ankle
- Arthrogram Foot Therapeutic Injection (Pain Management)

Do you have a Pacemaker/Defibrillator, Aneurysm Clip/Coil, Stimulator, Ear Implant, Breast Tissue Expander, or any other metal inside your body? Yes No If yes, please specify: _____
 (Initial) _____

Did you bring a driver with you? Yes No

Are you currently taking medications containing Aspirin or any other blood thinning medications? Yes No
 If yes, please list name of meds and last dose taken:

_____, _____, _____, _____
 List all medications you are currently using, as well as any taken in the last three (3) months: _____

Patient Signature: _____ Date: _____
 Technologist Signature: _____ Date / Time: _____