

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):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Previous Imaging Studies Related to Todays Exam	Date
Previous Surgeries Related to Todays Exam (e.g. Spinal fusion, Laminectomy, Spinal stimulator, etc.)	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)**

- Myelogram Lumbar Spine       Myelogram Thoracic Spine       Complete Cisternogram
- Myelogram Cervical Spine       Myelogram Complete       Lumbar Puncture

Per your Insurance, what laboratory do you use? (I.E. QUEST, LMC, OR LABCORP) \_\_\_\_\_

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: \_\_\_\_\_