SDMI STEINBERG DIAGNOSTIC

INVASIVE PROCEDURE INTAKE
ARTHROGRAM/PAIN MANAGEMENT

First Name _____ Last Name _____ DOB/Age _____

Allergies/Include reaction(s) _____

Height _____ Weight _____ Patient# (Internal use only) _____

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 Iliopsoas** ☐ **Arthrogram Ankle**

☐ **Arthrogram Elbow** ☐ **Arthrogram Hip** ☐ **Arthrogram Foot**

☐ **Arthrogram Wrist** ☐ **Arthrogram Knee** ☐ **Therapeutic Injection (Pain Management)**

Do you have a Pacemaker/Defibrillator, Aneursym 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:** _____