PATIENT HISTORY

and Procedure Form

CHEYENNE RADIOLOGY

Name: _____ Birthdate:_____

Age: _____ Sex: _____ Weight: _____ Height: _____

Family Doctor _____ Ordering Doctor: _____

Do you have X-rays / CT / MRI or other studies relating to this exam?_____

Symptoms you are having: _____

Do you have any of the following?

Hypertension	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Allergies	☐ Yes ☐ No
Generalized Severe Debilitation	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No	Blood Thinners/Aspirin Therapy	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Last time Taken _____	
Are you on glucophage? or metformin?	☐ Yes ☐ No	Heart Condition	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	If so, describe _____	

Other medical conditions: _____

List medication you are taking: _____

_____

List allergies to medications: _____

List allergic reactions you may have:_____

Any previous surgery on the part being examined today? ☐ Yes ☐ No

If yes, what type of surgery? _____

Female patients, any chance of pregnancy? ☐ Yes ☐ No

I have answered the above questions and all information is correct to the best of my knowledge.

Patient's Signature: _____ **Date:**_____

Technologist's Signature: _____

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The following is to be filled out by the Technologist or Registered nurse:

Blood pressure _____ Pulse_____ O2 stats_____

History of alcohol use – amount / frequency_____

RN/Technologist Initials_____ Date: _____