GENERAL HISTORY

Patient Name ____________________

Male ______ Female ______ Height ________ Weight (lbs.) __________

Age _______ DOB ____________________ **MRN** ____________________

History What symptoms are you experiencing? Why has your doctor requested this exam?

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Injury Have you had an injury? How and when did it occur? Have you been treated for this injury?

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Location Where is your pain, or symptom, located?

○Right ○Left ○Both Body part: ____________________

Severity If you are in pain, how bad is the pain on a scale of 1 - 10? Mild 1 2 3 4 5 6 7 8 9 10 Severe

Duration How long have you had this problem? Began recently __________ Chronic (long time)______________

Is the problem/symptom getting better or worse? ○Better ○Worse ○Staying the same ○N/A

Medications List any medications you currently take, along with dosage for each:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Cancer Do you have a history of cancer? ○No ○Yes **If yes, what type?** ____________________

If yes, what type of non-surgical cancer treatments have you had in the past?

○Radiation Therapy When?______________ ○Hormone Therapy When? ______________

○Chemotherapy When? ______________ ○Alternative Medicine When?______________

Surgical History Please list all operations, surgeries, or other significant medical procedures you have had during your lifetime, with approximate dates (including cancer treatment): ○I have not had any significant procedures

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Women Only Are you pregnant? ○No ○Yes ○N/A________________

Is there a chance you may be pregnant? ○No ○Yes ○Don't know

Are you currently breast feeding? ○No ○Yes Date of last breast feeding ______________

Date of last menstrual period ____________________

Patient Signature ______________________________ **Date** ______________

Technologist Notes: ______________________________

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Reviewed by Technologist:______________________ **Date**____________ **Time** ______ **am / pm**