Advanced Radiology

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?**

_____

_____

_____

Relevant Prior Imaging **Have you had prior imaging at another facility related to today's exam?** ○No ○Yes

If yes, where: ○ Norwalk Hospital ○ St. Vincent's Hospital ○ Bridgeport Hospital

○ Griffin Hospital ○ Stamford Hospital ○ Yale Hospital

○ Other location: Please indicate where: _____

Date(s) and type(s) of prior imaging: _____

_____

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

_____

_____

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

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?_____

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: _____

Clinical History: _____

Relevant Prior Imaging: _____

Relevant Surgery: _____

Reviewed by Technologist: _____ Date _____Time _____ am / pm