

Name: _____ MRN: _____

Phone (H) _____ (W) _____ (C) _____

Procedure _____ Date _____ Time _____

Referring MD _____ Office Phone _____

1. Major (chief) complaint _____

When and how did pain begin? _____

Description of pain _____

2. Mark the areas of your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Ache a a a
 a a a

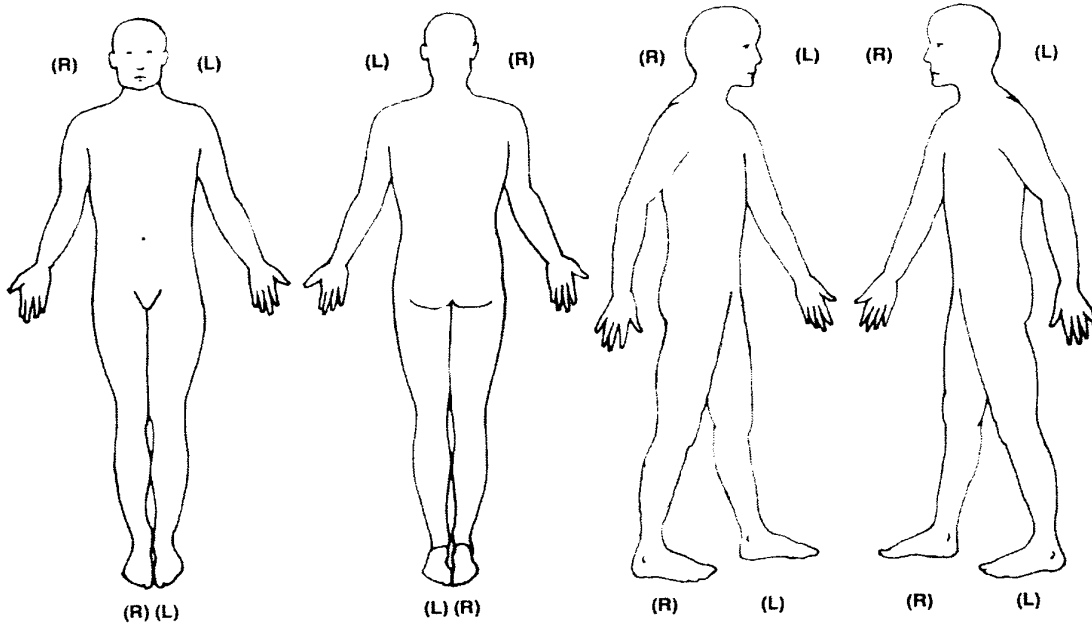
Burning x x x
 x x x

Numbness = = =
 = = =

Stabbing / / /
 / / /

Pins & needles o o o
 o o o

Weakness w w w
 w w w



3. Do you have any history of the following?

High Blood Pressure Yes No

Heart Disease Yes No

HIV Yes No

Kidney Disease Yes No

Hepatitis B or C Yes No

Diabetes Yes No

4. Have you had any of the following tests that pertain to the area we are imaging today?

At which facility / approximate date

CT Scan Yes No _____

MRI Scan Yes No _____

X-rays Yes No _____

5. What medications do you take? _____

6. What are you allergic to? _____

7. Have you had any surgeries in the area that we are imaging today? _____

8. Have you had injections in the areas that we are imaging today? _____

9. Do you go back to your doctor today? If not, when is your follow-up appointment?

10. Is there any possibility that you are pregnant? Yes No

Are you breast feeding? Yes No

Office Use Only:

Remind Patient to bring their insurance card / L&I #

Remind pt to bring a driver

NPO after midnight except for water, milk, and juice.

No Caffeine for 24 hours prior to injection.

No blood thinners for 3 days prior to injection.

Pt aware that the procedure lasts about 4 hours - advised to lie down the rest of day

Remind pt to bring any prior films

Vitals:

At arrival: _____

Post Exam: _____

Additional Comments:
