PATIENT CLINICAL HISTORY FORM

Patient Name:_____**Ht.**_____ **Wt.**_____ **DOB** _____

- Reason for Exam_____

  _____
- Onset of Symptoms**?**_____
- Injury? □ NO □YES EXPLAIN**:**_____ Date of Injury_____
- Previous Cancer? □ NO □ YES LOCATION**:**_____
- **Any previous surgeries?** _____

  _____

Prior Imaging Studies Related to Above Symptoms:

Type of Study:	**Date**	**Facility**
Radiographs (X-rays)	_____	_____
Computed Tomography (CT)	_____	_____
MRI	_____	_____
Other	_____	_____

Please bring these films with you, if possible, on the day of your exam.

**********TO BE COMPLETED BY DEPARTMENTAL STAFF**********

Contrast Type: _____ Amount:_____ NDC/Lot # _____

Creatinine: _____ GFR:_____ Result Date_____

Injection Site Information:

Angiocath	**Butterfly**	**Injection Site**		
_____18ga.	_____21ga.	_____Wrist	Rt.	Lt.
_____20ga.	_____23ga.	_____Antecubital	Rt.	Lt.
_____22ga.	_____25ga.	_____Hand	Rt.	Lt.
		_____Forearm	Rt.	Lt.

Technologist:_____Date:_____Radiologist:_____

Technologists Notes:_____

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