

THE IMAGING CENTER



OF LAS CRUCES RADIOLOGY

160 Roadrunner Pkwy. • Las Cruces, NM 88011
 Phone: 505-556-1800 • Toll Free: 888-522-6631
 Fax: 505-522-1178



1. Is the procedure (s) you are having today due to an injury yes no
2. Describe in detail how this injury occurred

4. Date of onset _____
5. Date of injury _____
6. Weight _____

3. Do you smoke yes no
 How long _____?
- A. Describe any complications or symptoms you are experiencing. _____

- B. Please give history of ALL Surgical procedures you have had

C. The following items may be hazardous or may interfere with the examination by producing an artifact. Please check the box side the items if you have any of them listed below.

<input type="checkbox"/> Cardiac Pacemaker	<input type="checkbox"/> Swan-Ganz catheter	<input type="checkbox"/> Vascular access port
<input type="checkbox"/> Artificial Heart	<input type="checkbox"/> Halo vest or cervical fixation device	<input type="checkbox"/> Intraventricular shunt
<input type="checkbox"/> Stents	<input type="checkbox"/> Any type of electronic, mechanical, or magnetic device	<input type="checkbox"/> Diaphragm
<input type="checkbox"/> Heart valve prosthesis	<input type="checkbox"/> Ear implant, hearing aid middle ear prosthesis	<input type="checkbox"/> IUD
<input type="checkbox"/> Aneurysm clip(s)	<input type="checkbox"/> Implanted drug infusion device	<input type="checkbox"/> Pessary
<input type="checkbox"/> Implanted Cardiac defibrillator	<input type="checkbox"/> Any type of intravascular coil, filter, or stent	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Neuro stimulator	<input type="checkbox"/> Penile presthesis	<input type="checkbox"/> Implanted orthopedic (pins, plates, screws)
<input type="checkbox"/> Any type of biostimulator	<input type="checkbox"/> Eye implant, metallic eye	<input type="checkbox"/> Artificial limb
<input type="checkbox"/> Any type of electrode(s) : pacing wire, cochlear implant	<input type="checkbox"/> Any type of surgical clip	<input type="checkbox"/> Any type of foreign
<input type="checkbox"/> Implanted insulin pump		<input type="checkbox"/> Any type of patch
<input type="checkbox"/> Wig		<input type="checkbox"/> Other _____
<input type="checkbox"/> Dentures, false teeth, braces, retainers		_____
<input type="checkbox"/> Tattooed eyeliner		_____
<input type="checkbox"/> Any type of implant held by magnet		_____

D. If you checked any of the above, please give a detailed history: _____

E. Complete the following ONLY if contrast if being ordered for your exam.

1. List the medications you are currently taking

3. Have you ever had an MRI with IV contrast yes no
4. Did you have a reaction to the IV contrast yes no
5. Are you breastfeeding yes no
6. Do you have asthma yes no

2. Do you have any allergies to any medications? If yes, please list

continued on other side

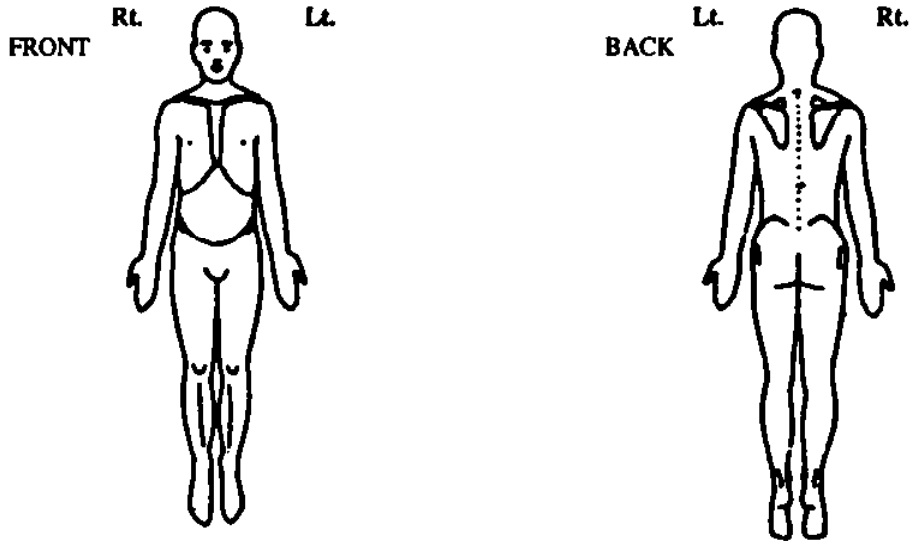
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F. Please shade all affected areas



History of previous studies.

G. Indicate if you have previously had any of the following exams pertaining **ONLY** to the scan that you are having today.

- MRI Angiogram Ultrasound
- Cat Scan X-rays Nuclear Med.

1. Did you bring them yes no
2. Date of procedure _____
3. Location(s) where the exam was performed _____

I attest that the above information is correct to the best of my knowledge. I have read and understood the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient's signature _____

Date _____

Print your name _____

MD/RN/RT signature _____

Date _____