SPRING HILL MRI

Patient Name: _____ PT #: _____

Home Phone: (_____) _____ - _____ Alternate Phone: (_____) _____ - _____ EXT:_____

Address: _____ Apt # : _____

City: _____ State:_____ Zip: _____

Social Security #: _____ **Date of Birth:** _____ **Age:** _____ **Sex**_____

Drivers License: _____ Marital Status: S / M / W / D Spouse Name:_____

Emergency Contact: _____ Phone:(_____) _____ - _____

PATIENT HISTORY – ALL PATIENTS

Today's Date: _____ What is your current weight:_____

Please describe the symptoms you are experiencing:_____

1. Do you have any of the following:

☐ **Cardiac Pacemaker**	☐ Cochlear(EAR) Implant or Prosthesis	☐ **Hearing Aids**	☐ **Neurostimulators**
☐ Infusion Pumps	☐ Dentures/Partials/Braces/Retainer	☐ **Intracranial Aneurysm Clips**	☐ **Patch (nicotine, pain, etc)**
☐ Shrapnel/Bullets	☐ Orbital Implant or Prosthesis	☐ Prosthetic Heart Valve	☐ Metal Fragments in Eye
☐ Intrauterine Device	☐ Inferior Vena Cava (IVC) Filter/Umbrella	☐ Penile Implant	

OR- ☐ **I attest that I DO NOT have any of the above**

2. Have you ever had surgery? ☐ No ☐Yes, list: _____

_____

3. Are you taking any medications? ☐ No ☐Yes, list: _____

_____

4. Are you allergic to any medications? ☐No ☐Yes, list: _____

5. For **Women ONLY**, is there a possibility of pregnancy? ☐ No ☐ Yes ☐Not Applicable

6. Is this a result of an injury?: ☐ No ☐ Yes: Date of Injury: _____

Was the injury a result of: ☐ Auto Accident ☐ Work Related Injury ☐ Slip and Fall ☐ Other:_____

State Vehicle Registered: _____

Briefly describe what happened? _____

_____

PATIENT HISTORY – MAMMOGRAPHY PATIENTS ONLY

1. Do you have breast implants? ☐No ☐Yes
2. Do you have a history of breast surgery? ☐No ☐Yes
3. Do you have a personal history of breast cancer? ☐No ☐Yes
4. Do you have a family history of breast cancer? ☐No ☐Yes
   If yes, what relation: _____
5. Do you have a personal history of ovarian cancer? ☐No ☐Yes
6. Do you have a family history of ovarian cancer? ☐No ☐Yes
   If yes, what relation: _____
7. Do you take any hormone medications? ☐No ☐Yes
   If yes, What type: _____How long:_____
8. Date of last menstrual period:_____
9. Date of last mammogram:_____
10. Where:_____

Reason for Today's Exam

Screening	☐RT	☐LT
Pain	☐RT	☐LT
Lump	☐RT	☐LT
Nipple Discharge	☐RT	☐LT

Other: _____

_____

I agree that all the information on this form is true and accurate to the best of my knowledge.

_____ _____ _____

Signature Printed Name Date