PATIENT INFORMATION SHEET - 11/23/2022

RAYUS Radiology Bellevue

Patient (Last, First, Middle) | MRN | Sex | DOB | Age | Radiologist (Last, First, Initial)

Females: Pregnant? ☐ Yes ☐ No Breastfeeding? ☐ Yes ☐ No Last Menstrual Period? _____

Do you have a follow up appointment? ☐ Yes ☐ No **Appt with:** _____ Date: _____

Describe your symptoms including pain, location, and side of body (right, left, or both):

_____

_____

_____

_____

How long have you had your symptoms? _____

Do you have any other known conditions that are related to your current symptoms? ☐ Yes ☐ No

Describe: _____

Is your exam to evaluate an injury or fracture? ☐ Yes ☐ No

If Yes, where, when, and how did the injury occur?

_____

If yes, what is the location of the injury/bone including side of body: _____

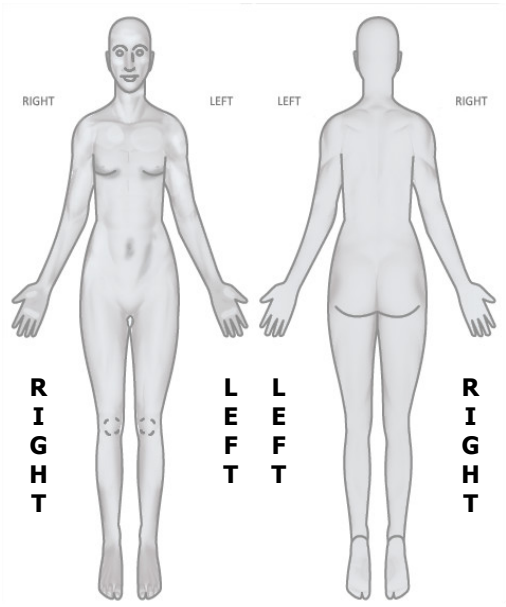
If yes, is this exam being obtained to evaluate:

☐ a new injury ☐ to follow or evaluate healing ☐ symptoms secondary to an old injury

Are the symptoms related to an auto accident? ☐ Yes ☐ No Date: _____

Anatomy	***Location***		***Symptom(s)***			
Neck	☐ Left	☐ Right	☐ Pain	☐ Tingling	☐ Weakness	☐ Numbness
Back	☐ Left	☐ Right	☐ Pain	☐ Tingling	☐ Weakness	☐ Numbness
Left Arm			☐ Pain	☐ Tingling	☐ Weakness	☐ Numbness
Right Arm			☐ Pain	☐ Tingling	☐ Weakness	☐ Numbness
Left Leg			☐ Pain	☐ Tingling	☐ Weakness	☐ Numbness
Right Leg			☐ Pain	☐ Tingling	☐ Weakness	☐ Numbness

Please shade in affected areas



Have you had surgery on area being scanned? ☐ Yes ☐ No

If yes, when: _____

Symptoms since surgery: ☐ Better ☐ Worse ☐ Same ☐ Different

Describe what was performed:

_____

_____

Have you had radiation therapy on area being scanned? ☐ Yes ☐ No

Are you being evaluated for a possible cancer or currently being treated for cancer? ☐ Yes ☐ No

Describe: _____

Is the exam being ordered because of an abnormal laboratory or imaging test? ☐ Yes ☐ No

Describe: _____

Have you had any of these treatments?

☐ Yes ☐ No Physical therapy

☐ Yes ☐ No Oral medication prescribed by a doctor

☐ Yes ☐ No Chiropractic therapy

☐ Yes ☐ No Other: (i.e. acupuncture, heat/ice, over-the-counter medications)

Combined total # of weeks using any of these treatments: _____ weeks

Height: _____ Ft. _____ In.

Weight: _____

Blood Pressure: _____ / _____

Date Last Taken: _____

☐ Patient Refused

☐ Patient/Clinic Reported

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Check the corresponding box if you have ever had any of the following medical conditions:

Head / Neck

- ☐ Blurred Vision
- ☐ Dizziness
- ☐ Buzzing or Ringing
- ☐ Hearing Loss
- ☐ Bell's Palsy
- ☐ Head Trauma
- ☐ Head Surgery
- ☐ Headaches
- ☐ Seizures
- ☐ Vertigo
- ☐ Thyroid Problems
- ☐ TMJ Problems / Surgery

Chest / Lung

- ☐ Asthma
- ☐ Bronchitis
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Emphysema

☐ Other: _____

Abdomen / Pelvis

- ☐ Gallbladder Problems
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Pancreas Problems
- ☐ Prostate Problems

Other

- ☐ Claustrophobia
- ☐ Bleeding Disorder
- ☐ History of Cancer:

Type _____

When _____

- ☐ Diabetes
- ☐ Immunosuppression
- ☐ High Blood Pressure
- ☐ Long Term Steroid Use
- ☐ Osteoporosis

Smoking Status: ☐ Never Smoked ☐ Smokes; but not every day ☐ Smokes; every day ☐ Former Smoker

Pack years (# packs per day x # of years smoked): _____

Former smokers only: How many years ago did you quit smoking? _____

Previous Imaging on Area Being Scanned:

☐ X-Rays	Date:		Facility:	
☐ CT Scan	Date:		Facility:	
☐ MRI Scan	Date:		Facility:	
☐ Ultrasound	Date:		Facility:	
☐ Nuclear Medicine	Date:		Facility:	
☐ Therapeutic Injection	Date:		Facility:	
☐ Arthrogram	Date:		Facility:	

Current Prescription Medications:

_____

_____

Allergies:

Allergies to latex? ☐ Yes ☐ No

Allergies to iodine, CT contrast or MRI contrast? ☐ Yes ☐ No Contrast Type: _____

Severity: ☐ Mild ☐ Moderate ☐ Severe

Drug/Med Allergy: _____ Reaction (if known): _____

Severity: ☐ Mild ☐ Moderate ☐ Severe

Drug/Med Allergy: _____ Reaction (if known): _____

Severity: ☐ Mild ☐ Moderate ☐ Severe

Drug/Med Allergy: _____ Reaction (if known): _____

Severity: ☐ Mild ☐ Moderate ☐ Severe

Seasonal or food allergies? ☐ Yes ☐ No List: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declined

Race: ☐ American Indian or Alaska Native ☐ Black or African American ☐ Asian ☐ White ☐ Hawaiian / Pacific Islander ☐ Some other race ☐ Patient Declined

Preferred Language:

☐ English ☐ Spanish ☐ German ☐ Arabic ☐ Somali ☐ Patient Declined
☐ Chinese ☐ French ☐ Bengali ☐ Russian ☐ Hmong ☐ Other:

Communication Preferences:

☐ Home Phone _____ ☐ Mobile Phone _____ ☐ Work Phone _____

☐ E-Mail _____ ☐ Mail Address _____