inclusive MRI &Diagnostics
12000 RICHMOND AVE. SUITE #125
HOUSTON, TX 77082
281-720-8688 281-720-7225

MR #: _____

X-RAY HISTORY AND SCREENING FORM

Patient Name: _____ Date: _____

Sex: **M** **F** Height: _____ Weight: _____ DOB: _____ Age: _____

Referring Physician: _____

Are you pregnant: **YES** **NO** **N/A** Last Menstrual Period: _____ Are you breast feeding at this time? **Yes** **No**

Reason you are here today for an exam:

Explain your medical problem in detail. ***(What happened? Where did it happen? How long have you had this problem?)***

_____

_____

_____

Do you have pain? **YES** **NO** Where? _____

Have you had any surgeries in the area(s) that are being imaged today? **YES** **NO** Where: _____

Have you taken any medication/sedation/alcohol today to help you relax for this procedure? **YES** **NO**

If yes, please list: _____time taken: _____

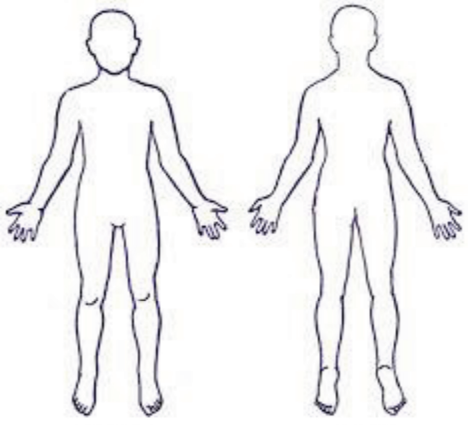
Have you had a previous exam related to this problem? **YES** **NO** If yes, explain: _____

Do you have any of the following? **(circle, if yes, please explain)**

Yes **No** Asthma _____
Yes **No** Allergic Respiratory Disease _____
Yes **No** Diabetes _____
Yes **No** Kidney Disease _____
Yes **No** Cancer _____
Yes **No** Multiple Myeloma _____
Yes **No** Prostate Problems _____
Yes **No** Dizziness _____

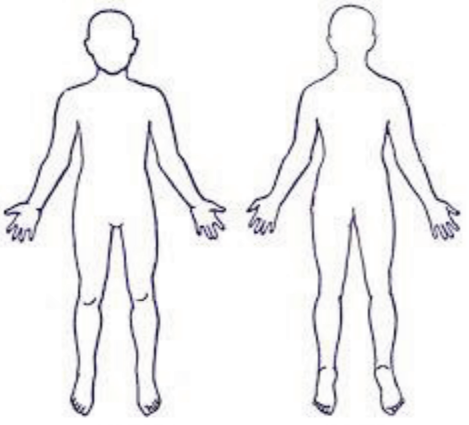
Yes **No** Heart Disease _____
Yes **No** Stroke _____
Yes **No** Liver Disease _____
Yes **No** Seizure Disorder _____
Yes **No** Bladder Disease _____
Yes **No** Headaches _____
Yes **No** Orthopedic Pins/Rods/Screws/Plates/etc.
_____

Draw where your pain or symptoms are located on the figure below:



FRONT BACK

Draw the location of any metal in your body on the figure below:



FRONT BACK

Acknowledgement: I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that at this time I am **pregnant OR NOT pregnant** (circle)**.**

_____ _____ _____

Patient/Parent/Legal Guardian Signature Technologist Date

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INFORMED CONSENT FOR X-RAY

You have the right to be informed about the diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you. It is so that you may choose to give or withhold your consent to the procedure.

If you are pregnant or think that you may be pregnant, please inform the technologist at once.

Your physician has requested that we perform x-rays to obtain additional information. This is a diagnostic test that involves x-ray images and a computer to produce an image of internal body parts.

Your physician believes an x-ray to be the best diagnostic test for you, considering your symptoms and condition. The benefit of this exam is to assist your physician with a diagnosis.

I (WE) CERTIFY THIS FORM HAS BEEN FULLY EXPLAINED TO ME, I (WE) HAVE READ IT OR HAVE HAD IT READ TO ME (US), THE BLANK SPACES HAVE BEEN FILLED IN AND THAT I (WE) UNDERSTAND ITS CONTENTS.

THE PROCEDURES TO BE USED, AND THE RISKS AND HAZARDS INVOLVED, AND I (WE) BELIEVE THAT I (WE) HAVE SUFFICIENT INFORMATION TO GIVE THIS INFORMED CONSENT.

Patient Name Printed: _____

Patient Signature: _____

Date: _____Time: _____: _____ AM or PM

Witness Name Printed: _____

Witness Signature: _____

Date: _____Time: _____: _____ AM or PM