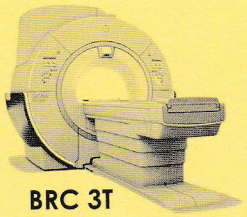
BRISTOL
# Radiology CENTER
Diagnostic Imaging Specialists


BRC 3T

25 Collins Road, Bristol, CT 06010 • 860-584-0541 • Fax 860-584-9998
www.bristolrad.com

Patient Name_____, D.O.B_____, WT____, HT_____, Exam Date/Time_____
PH: Home_____, Cell_____, Work_____
Physician_____, Physician signature_____, Exam_____
Precert #_____, Insurance_____, CPT Code_____ICD-10_____
Clinical History:_____

**Please indicate if you currently have or ever had any of the following:**

| | YES | NO |
|---|---|---|
| Cardiac pacemaker / Pacer wires | ☐ | ☐ |
| Implanted cardiac defibrillator (ICD) | ☐ | ☐ |
| Aneurysm clips | ☐ | ☐ |
| Intravascular coil, filter, stent, or graft (AAA) | ☐ | ☐ |
| Chest surgery, heart valve, cardiac stent | ☐ | ☐ |
| Shunt, (Spinal/Intraventricular) | ☐ | ☐ |
| Eye surgery, eyelid spring or wire | ☐ | ☐ |
| Cataracts/detached retina | ☐ | ☐ |
| Magnetically activated implant or device | ☐ | ☐ |
| Spinal cord/bone growth stimulator | ☐ | ☐ |
| Implanted drug infusion device/pump, ie: Insulin, Baclofen | ☐ | ☐ |
| Surgical staples, clips, sutures or mesh | ☐ | ☐ |
| Prosthetic limb/eye/penile/breast tissue expander | ☐ | ☐ |
| Vascular access-port and/or catheter | ☐ | ☐ |
| Cochlear/otologic or other ear implant (including hearing aid) | ☐ | ☐ |
| Electronic implant or device, Ex: neurostimulator, TENS, VNS, DBS | ☐ | ☐ |
| Spine fusion procedure, Ex: Harrington rod | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| Radiation seeds or implants | ☐ | ☐ |
| IUD, diaphragm or pessary | ☐ | ☐ |
| Any metallic fragments or foreign body | ☐ | ☐ |
| Shrapnel or gunshot wounds | ☐ | ☐ |
| Joint replacements: hip, knee, etc | ☐ | ☐ |
| Bone/joint, pin, screw, nail, wire, plate | ☐ | ☐ |
| Braces, dentures or partial plates | ☐ | ☐ |
| Tattoo or permanent make up | ☐ | ☐ |
| Body piercing jewlery | ☐ | ☐ |
| Wig or hair implant - hair accessories | ☐ | ☐ |
| Breathing problem or motion disorder | ☐ | ☐ |
| Pregnant or breast feeding | ☐ | ☐ |
| Claustrophobia | ☐ | ☐ |
| Colonoscopy or Endoscopy w/in 2 months, camera/clips | ☐ | ☐ |
| Medical patch (transdermal), EX: Nicotine, nitroglycerine | ☐ | ☐ |
| Penetrating eye injury w/metal: Year_____, MRI since_____ | ☐ | ☐ |

**Allergies - food, meds, latex, contrast media**

_____
_____

**List surgeries:**

_____
_____
_____
_____
_____
_____
_____
_____

**History of:**

| | | |
|---|---|---|
| Diabetes | ☐ | ☐ |
| Gout | ☐ | ☐ |
| HTN | ☐ | ☐ |
| Kidney disease | ☐ | ☐ |
| Cancer | ☐ | ☐ |

I have understood and accurately answered all of the above questions.
The technologist has answered any questions that I have had regarding the procedure.
Legal guardian, if patient is a minor, or unable to give consent

_____ _____
Signature Date

_____ _____
Printed Name Date