

**TECHNOLOGIST-PATIENT INTERVIEW FORM**

Type of Scan: \_\_\_\_\_ Patient Record #: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ Chart #: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
 BUN: \_\_\_\_\_ Creatinine: \_\_\_\_\_

1. Describe your symptoms: \_\_\_\_\_
2. How long have you had these symptoms? \_\_\_\_\_
3. What type of treatment have you received so far for these symptoms? \_\_\_\_\_

4. Is your problem due to an injury? \_\_\_\_\_  
 Date of injury: \_\_\_\_\_  
 What type of injury? \_\_\_\_\_
5. Have you had any previous studies in the area of interest: Yes No Ultrasound: \_\_\_\_\_ MRI: \_\_\_\_\_ X-Ray: \_\_\_\_\_  
 CAT scan: \_\_\_\_\_ Nuclear Medicine: \_\_\_\_\_ other: \_\_\_\_\_

6. Have you had any previous surgeries: Yes No Type: \_\_\_\_\_  
 Date: \_\_\_\_\_ Where: \_\_\_\_\_
7. List any medical illnesses: \_\_\_\_\_

8. List any medications taken: \_\_\_\_\_

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|--|--------------------------|---|---|--------------|
| Are you Allergic to:                             | Iodine                   | Y | N |              |
|  | Seafood                  | Y | N |              |
|  | Plants                   | Y | N |              |
|  | Animals                  | Y | N |              |
|  | Medications              | Y | N | Other: _____ |
|  | Are you Pregnant         | Y | N |              |
|  | Possibly Pregnant        | Y | N | LMP: _____   |
| Do You Have:                                     | Asthma                   | Y | N |              |
|  | Diabetes                 | Y | N |              |
|  | Multiple Myeloma         | Y | N |              |
|  | Shortness of Breath      | Y | N |              |
|  | Heart Disease            | Y | N |              |
|  | High Blood Pressure      | Y | N |              |
|  | Kidney Disease           | Y | N |              |
|  | Dehydration              | Y | N |              |
| Do you take                                      | Glucophage or Metformin? | Y | N |              |
| Have you had a prior study with contrast?        |                          | Y | N |              |
| Have you had IV contrast with the last 24 hours? |                          | Y | N |              |

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|--|---|---|
| 9. Have you had any surgical procedure resulting in an implanted metallic device?            | Y | N |
| 10. Has a metallic object ever injured you?  | Y | N |
| 11. Do you have anemia or diseases that affect the blood?                                    | Y | N |
| 12. Do you have a history of cancer?   | Y | N |
| 13. Do you have a history of renal disease, seizure, asthma or allergic respiratory disease? | Y | N |
| 14. Are you allergic to any drugs?   | Y | N |
| 15. Have you ever had a reaction to a contrast medium used for MRI?                          | Y | N |
| 16. Is there a possibility for pregnancy at this time?                                       | Y | N |
| 17. Are you breast-feeding?  | Y | N |
| 18. Are you taking oral contraceptives or receiving hormone treatment?                       | Y | N |
| 19. Have you had contact with a person known to have tuberculosis?                           | Y | N |

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|-------------------------------------|---|---|--|---|---|
| 20. Cardiac Pacemaker               | Y | N | 36. IUD  | Y | N |
| 21. Aneurysm Clip(s)                | Y | N | 37. Tattoo                                       | Y | N |
| 22. Implanted Cardiac Defibrillator | Y | N | 38. Any Type of Biostimulator                    | Y | N |
| 23. Neurostimulator                 | Y | N | 39. Halo Vest/Metallic Cervical Fixation Device  | Y | N |
| 24. Implanted Insulin Pump          | Y | N | 40. Any Type of Implant Held in Place by Magnet  | Y | N |
| 25. Swan-Ganz Catheter              | Y | N | 41. Any Type of Surgical Clips or Staples        | Y | N |
| 26. Heart Valve Prosthesis          | Y | N | 42. Any Type of Foreign Body, Shrapnel or Bullet | Y | N |
| 27. Hearing Aid                     | Y | N | 43. Metallic Fragments in the Eye                | Y | N |
| 28. Any Type of Ear Implant         | Y | N | 44. Implanted Drug Fusion Device                 | Y | N |
| 29. Penile Prosthesis/Implant       | Y | N | 45. Pessary                                      | Y | N |
| 31. Vascular Access Port            | Y | N | 47. Wire Mesh                                    | Y | N |
| 32. Intraventricular Shunt          | Y | N | 48. Electronic, Mechanical or Magnetic Implant   | Y | N |
| 33. Artificial Limb or Joint        | Y | N | 49. Intravascular Coil, Filter or Stent          | Y | N |
| 34. Dentures                        | Y | N | 50. Internal Electrodes                          | Y | N |
| 35. Diaphragm                       | Y | N | 51. Implanted Orthopedic Item                    | Y | N |

Technologist Notes: \_\_\_\_\_  
 Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Technologist: \_\_\_\_\_ Contrast Reaction: \_\_\_\_\_ Meds Given: \_\_\_\_\_