NORTH CENTRAL SURGICAL CENTER HOSPITAL

Patient History Form Patient Sticker:

1. What **part of the body** are we imaging today? _____

2. Please describe your **symptoms** relating to the body part we are imaging: _____

   How long have you had these symptoms and/or pain? _____

   Location of your pain*?* _____

   If you have **Radiating pain**; what side? ☐ Right ☐ Left ☐ Both ☐ N/A
   Where does the pain radiate to? _____

   Does the pain become intense during physical activity such as brisk walking, exercise or sports?
   ☐ Yes ☐ No ☐ N/A

3. Please explain if you have limited range of motion. _____

4. Was this due to an **accident, fall or trauma**, please provide details and how long ago?
   _____

5. Have you had **previous Surgery to the part of the body we are imaging today**?
   _____

6. Prior **X-rays, CT, MRI or Ultrasound**, please list the facilities where this was done and the body part imaged.
   _____

FALL ASSESSMENT:

Have you fallen in the last 3 months? ☐ Yes ☐ No

Do you take medications for anxiety, depression or sleeping? ☐ Yes ☐ No

Do you experience unsteadiness, dizziness or vertigo? ☐ Yes ☐ No

Do you use a cane, walker or wheelchair? ☐ Yes ☐ No

FEMALE PATIENTS: Pregnancy Screening (11 years – 60 years old):

MALE PATIENTS: Please mark N/A

Have you had a hysterectomy (removal of the uterus)? ☐ Yes ☐ No ☐ N/A

Have you gone through menopause? ☐ Yes ☐ No ☐ N/A

Do you have any reason to believe you might be pregnant? ☐ Yes ☐ No ☐ N/A

If yes, please notify the staff.

If the information above indicates a remote possibility of pregnancy, you will be asked to have a pregnancy test prior to any exam involving an X-ray, CT or MRI or you have the option to refuse and sign a waiver.

Patient Signature: _____ Date: _____ Time: _____

Staff Signature: _____ Date: _____ Time: _____