MedStar Georgetown University Hospital

MedStar Georgetown Radiology
Procedure Information Worksheet

PATIENT IDENTIFICATION:

Last Name: ______________________________ First Name: __________________________________ Middle Initial: _________

Date of Birth: _________ /________ / _________ Sex: ❑ Female ❑ Male

Date of Service: _______ /________ / _________ Referring Physician: ____

Name of Individual Completing this form: ____________________________ Relationship to Patient: ______________________

PROCEDURE: *Please check the type of examination or procedure you are coming for today:*

❑ CT ❑ Nuclear Medicine ❑ Ultrasound ❑ X-Ray / Fluoroscopy

MEDICAL & SURGICAL HISTORY: *Please briefly describe the symptoms or conditions that prompted your physician to request this study:*

Please list type and year of any surgeries you have had:

Have you ever been diagnosed with cancer? . . . . ❑ Yes ❑ No

If yes, what type of cancer? ____

When was this diagnosis made? ____

Please list all of your allergies:

Please list all current medications:

Are you diabetic?. . . . . ❑ Yes ❑ No

If yes, are you taking Metformin or any medicine containing Metformin (Glucophage™, Glucovance™, Metaglip™ Actoplosmet™ Avandamet™)? . . . . ❑ Yes ❑ No

Are you pregnant or suspect that you may be pregnant? . . . . ❑ Yes ❑ No

Are you breastfeeding? . . . . ❑ Yes ❑ No

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MRUN ________________ Technologist Signature: ______________________________ Date: _______ Time: ______