Advanced Imaging Center

AUTHORIZATION FOR DISLOSURE OF PROTECTED HEALTH INFORMATION

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be nonapplicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. A copy of this signed form will be provided to the patient.

I, _____
Patient name Patient ID

hereby authorize AIC to dislose my health records generated at this facility to _____ for the purpose of conveyence of medical information. This consent is valid up to a year from the date of my exam. I may revoke or amend this consent at any time by notifying AIC in writing.

I understand that this will include information relating to (check and initial, if applicable):

Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection

Behavioral health service/psychiatric care

Treatment for alcohol and/or drug abuse

I understand that Advanced Imaging Center will receive compensation for its use/disclosure of the information release pursuant to this authorization, such as to a patient's insurance provider. Patient's initials: _____

Affirmation of Release:

I give Advanced Imaging Center permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.

_____ _____

Signature of the Patient/Guardian/Legal Representative Date Signed

Expiration Date: _____

Up to one year from date signed

Account# _____

WORK COMP PATIENTS

Name: _____

SS#: _____

Employer: _____

Employer's address: _____

_____

Employer's Tel#: _____

Supervisor (name & extension): _____

Date of injury: _____

Work comp insurance company: _____

Insurance company telephone: _____

Claim#: _____

Adjustor name and tel #: _____

Describe injury: _____

_____

Signature and date: _____

Advanced Imaging Center

Notice of Privacy Practices Patient Acknowledgement Form

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice Of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that my be made by this practice, my individual rights and the practice's legal duties with respect to my protected health insurance.

Advanced Imaging Center has implemented the following to protect and safeguard my health information:

Ongoing training for all employees on privacy policies and procedures

Established safeguards to protect all electronically stored data

Advanced Imaging Center will only use my personal information for

Planning care and retreat

Communication with my insurance provider

Communication with other health care professionals who may contribute to my care

Advanced Imaging Center does request my permission to have a

Sign-in sheet at the front desk

To call my daytime phone number to confirm my appointment

To call out my name at the time of my appointment

Advanced Imaging Center will get my written permission if they were to use my personal information for any reason other than the minimum necessary. My individual rights with respect to protected health information provides me with the right:

To revoke this consent in writing, except to the extent that Advanced Imaging Center has already taken action in reliance thereon

To inspect, amend, request restrictions in writing, get a copy of my medical information, and information about the disclosures they have made on my behalf

To complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint

---

By signing this agreement, I have read and understood this practice's Notice of Privacy Practices. Please do not hesitate to contact our privacy officer, at (661) 949-8111 if you have any questions, concerns or suggestions.

_____ _____

Signature of Patient or Legal Representative Witness Date

Advanced Imaging Center

Bone Densitometry
Medical History Questionnaire

Name: _____ Date: _____

Sex: _____ Age: _____ Height _____ Weight _____

Ethnic Background

1. Father: A: Caucasian B: Black C: Asian D: Native American E: Other: _____
2. Mother: A: Caucasian B: Black C: Asian D: Native American E: Other: _____

Medical History

Possible Causes of Osteoporosis

3. Have you ever had:
   a. Multiparity (5 or more pregnancies to term)
   b. Diabetes
   c. Thyroid Disease
   d. Parathyroid Disease
   e. Renal Dialysis
   f. Allergies (Severe)
   g. Immobilization (stroke, paralysis)
   h. Liver disease
   i. Hepatitis
   j. Multiple sclerosis
   k. Osteomalaoia
   l. Other disease process: _____

Family History

4. Has anyone in your family ever had:
   a. Breast cancer
   b. Uterine cancer
   c. Heart trouble
   d. Stroke
   e. Diabetes
   f. High blood pressure

5. Did your grandmother / mother ever:
   a. Fracture a hip
   b. Walk bent over forward
   c. Have a Dowager's hump
   d. Fracture a wrist
   e. Seem to get shorter as she aged

Present Bone Disease

6. Fracture of any bone: Yes No
7. Age when fracture occurred: _____
8. Which bone was fractured: _____
9. More than one fractured: Yes No
10. If 9 is Yes, did they all occur at the same time: Yes No
11. If 10 is No, did fractures occur at different times: Yes No
12. Do you have arthritis: Yes No
13. If Yes, number of years: _____
14. Your arthritis is: Mild Moderate Severe
15. Is there any bone deformity: Yes No
16. If Yes, number of years: _____
17. What type of deformity:
    a. congenital
    b. Dowager's Hump
    c. Scoliosis
    d. Hunchback

Advanced Imaging Center

MAMMOGRAPHY DEPT

NAME: _____ **DOB:** _____

DOCTOR: _____ **XR#:** _____

Have you had a previous Mammogram? No Yes

If yes, when and where? _____

At what age did you start menstruating? _____ Age stopped? _____

Have you ever been pregnant? No Yes

If yes: Your age at first pregnancy: _____ Number of births: _____

Did you breast feed? How long? No Yes _____

Have you ever taken birth control or hormones? No Yes

If yes: When and for how long? _____

Have you ever had a breast biopsy or breast surgery? No Yes

If yes: When? _____ Which breast? Left Right

Were the results benign (not cancer) malignant (cancer)

If malignant, did you have Radiation or Chemotherapy? No Yes

Do you have breast implants? No Yes

Do you have a family history of breast cancer? No Yes Who? _____

Are you having any breast problems at this time? No Yes If yes, what?

_____

PATIENT SIGNATURE: _____ **DATE:** _____

Translated by: _____

Advanced Imaging Center

Accredited by the
American College of Radiology

Patient Name: _____

Consent to Undergo X-Ray During Pregnancy

I hereby acknowledge that Advanced Imaging Center, LLC., ("AIC") through one of its representatives has discussed with me the issues concerning X-Ray during my pregnancy. Specifically, it has been explained to me that:

1. Exposure to radiation during pregnancy may cause Birth Defects.
2. Exposure to radiation during pregnancy may cause miscarriage.

AIC and/or persons acting on behalf of AIC have answered ANY AND ALL questions that I may have had. My risks and the risk to the fetus have been fully explained so that I may make an informed decision with regard to the X-Ray procedure. I further understand that I may contact AIC for any future questions I may have about the test.

After being given sufficient time to consider the benefits and risks of the X-Ray, specifically considering my pregnancy, any other medical condition that I may have and the possibility of damage to my baby, I hereby consent on behalf of myself and my fetus to undergo the X-Ray procedure.

I also acknowledge that my referring physician is aware and informed of my pregnancy.

That by signing this document, I agree that I have read and understand the warnings within. I release Advanced Imaging Center, Inc., its agents, officers, directors and employees from any and/or all liability with regards to my pregnancy and this service.

Date:

_____ _____

Patient Witness

_____

AIC Representative

* 43731 N. 15th St. West * Lancaster, CA 93534 * www.aicLancaster.com * Tel: (661) 949-8111 * Fax: (661) 949-6600
* 607 W. Ave Q * Palmdale, CA 93551 * Tel: (661) 456-2020 * Fax: (661) 456-2021
* 25842 Tournament Road * Valencia, CA 91355 * www.aicValencia.com * Tel: (661) 255-0060 * Fax: (661) 255-0024

Advanced Imaging Center

Patient Name: _____

Consent to Undergo MRI During Pregnancy

I hereby acknowledge that Advanced Imaging Center, LLC., ("AIC") through one of its representatives has discussed with me the issues concerning an MRI during my pregnancy. Specifically, it has been explained to me that:

1. MRI is a technique to look inside the body without using ionizing radiation. I will lie on a table for 60-90 minutes while pictures are being taken using magnetism and radio frequency waves. The MRI study will not require any injections or anesthesia, but if sedation is needed, I will be informed and allowed to consent.; and

2. Because an MRI uses magnetism and radio frequency waves, known risks include, damage to heart pacemakers and injury due to the presence of metal objects inside a persons body or in the examining room. Because MRI imaging is so new, the effects of an MRI on pregnant women, either to the mother or her fetus are NOT KNOWN. No conclusive research has been performed. Therefore, neither AIC and or any person acting on behalf of AIC, can exclude the possibility that there may be short-term or long-term hazards. In other words, AIC and persons acting on behalf of AIC do not know whether either my baby or myself will be damaged by an MRI.

AIC and/or persons acting on behalf of AIC have answered ANY AND ALL questions that I may have had. My risks and the risk to the fetus have been fully explained so that I may make an informed decision with regard to the MRI procedure. I further understand that I may contact AIC for any future questions I may have about this test.

After being given sufficient time to consider the benefits and risks of the MRI, specifically considering my pregnancy, any other medical condition that I may have and the unknown possibility of damage to me or my baby, I hereby consent on behalf of myself and my fetus to undergo the MRI procedure. I do not have a pacemaker or any dangerous implanted metal objects.

That by signing this document, I agree that I have read and understand the warnings within. I release Advanced Imaging Center, Inc., its agents, officers, directors and employees from any and/or all liability with regards to my pregnancy and this service.

Dated:

_____ _____

Patient Witness

_____

AIC Representative

Advanced Imaging Center

MRI Safety Questionnaire

Patient Name: _____ Date of Exam: _____

Please answer the following questions. If you are unsure of the answer, leave it blank

Do you have any of the following?	Circle Answer		
1. Claustrophobia	Yes	No	Not Sure
2. Cardiac Pacemaker/Defibrillator	Yes	No	Not Sure
3. Intracranial Bypass Graft Clips	Yes	No	Not Sure
4. Coronary Artery Bypass Clips	Yes	No	Not Sure
5. Aneurysm Clips	Yes	No	Not Sure
6. Renal Transplant Clips	Yes	No	Not Sure
7. Other Vascular Clips	Yes	No	Not Sure
8. Epilepsy	Yes	No	Not Sure
9. Middle Ear Prosthesis	Yes	No	Not Sure
10. Cardiac Valve Prosthesis	Yes	No	Not Sure
11. Orbital Prosthesis	Yes	No	Not Sure
12. Artificial Joint Prosthesis	Yes	No	Not Sure
13. Neurostimulator (Tens Unit)	Yes	No	Not Sure
14. Metal Mesh Implants	Yes	No	Not Sure
15. Dentures	Yes	No	Not Sure
16. Shrapnel	Yes	No	Not Sure
17. Harrington Rods	Yes	No	Not Sure
18. Metal Rods or Pins	Yes	No	Not Sure
19. Intracranial/Brain Surgery	Yes	No	Not Sure
20. Are you pregnant?	Yes	No	Not Sure
21. Have you had cataract surgery?	Yes	No	Not Sure
22. Have you ever worked with metal?	Yes	No	Not Sure
23. Have you ever had metal in your eye?	Yes	No	Not Sure
24. Have you had any previous surgeries?	Yes	No	Not Sure
25. Are you nursing?	Yes	No	Not Sure
26. Impaired Liver Function	Yes	No	Not Sure
27. Sickle Cell or other Blood Cell Diseases	Yes	No	Not Sure
28. Tattoo Eyeliner	Yes	No	Not Sure

Signature: _____ Date: _____

NOTES:

Advanced Imaging Center

Questionnaire & Consent for the Injection of Intravenous Contrast

Some patients are at higher risk for experiencing an allergic reaction or kidney damage. The following questions will help our physicians determine the best contrast agent for your particular study or if additional medication should be given.

Are you over 60?	**Yes**	**No**
Have you ever received x-ray contrast material?	**Yes**	**No**
If yes, did you ever have a reaction to the contrast?	**Yes**	**No**
Are you diabetic? Yes__ No__ Do you take insulin?	**Yes**	**No**
Are you taking (or have you taken) the drug GLUCOPHAGE (Metformin)?	**Yes**	**No**
Do you have asthma?	**Yes**	**No**
Are you allergic to any food or medication?	**Yes**	**No**

If yes, please tell us which: _____

Do you have any history of renal disease, including dialysis, kidney transplant, single kidney, renal cancer, renal surgery?	**Yes**	**No**
Do you have a history of hypertension requiring medical therapy?	**Yes**	**No**
Do you have Multiple Myeloma (bone cancer)?	**Yes**	**No**
Do you have Sickle Cell Anemia?	**Yes**	**No**
Do you have Polycythemia (excess in red blood cells)?	**Yes**	**No**
Are you currently taking any medications?	**Yes**	**No**

If yes please list: _____

Are you pregnant?	**Yes**	**No**

Your doctor has requested an examination that requires an intravenous injection of contrast material (also termed x-ray dye and contrast media). This contrast us used to visualize blood vessels and body organs. The contrast is administered through a small needle introduced in a vein, usually on the back of your hand or inside your arm.

Under usual circumstances the infusion of contrast materials is quite safe; however, any injection carries a slight risk of harm, which includes injury to a nerve, artery or vein, infection, kidney damage or an allergic reaction to the contrast. Allergic reactions in their mildest form may include itching, sneezing and hives. Serious reactions are uncommon; these symptoms include tightness in the throat and difficulty breathing. The physicians and staff of Advanced Imaging Center are trained to treat these reactions. Very rarely, (1 in 160,000) death occurs as a result of the administration of contrast material.

Once the injection of contrast material is completed, the needle will be removed and a bandage will be placed over the injection site. The material injected will be filtered by the kidneys and excreted in the urine. Unless you are on fluid restrictions, we suggest you increase your fluid intake for the next several hours following the procedure. Should you experience any problems following the procedure, please contact your physician immediately.

I HAVE ANSWERED THE QUESTIONS ABOVE TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE, I HAVE ALSO READ THE INFORMATION ABOVE AND CONSENT TO THE INJECTION OF CONTRAST MATERIAL.

_____ _____

Signature of Patient Date

_____ _____

Witness Date

_____ _____

Interpreter or Guardian/Relationship Date

Advanced Imaging Center

CONSENT FOR RADIOLOGY PROCEDURE

Patient Name: _____

INTRODUCTION:

Your physician has requested that you undergo a procedure known as a: _____

This procedure is being performed to further evaluate and/or treat your diagnosis of: _____

We are asking you to read and sign this form so that we can be sure you understand the risks and complications potentially associated with this procedure. Please ask questions about anything on this form that you do not understand.

DESCRIPTION OF PROCEDURE

This procedure involves the placement of a fine needle through your skin and into a designated location. Some numbing medicine will be injected in the skin over the site that will be used before the needle is inserted. Medications may also be given to you to make you more comfortable and relaxed. This is known as conscious sedation. Following insertion, the needle will be guided into position with a camera, using x-rays (fluoroscopy or CT), sound waves (ultrasound) or magnetic signals (MRI). The position of the needle may be confirmed by the injection of x-ray contrast material (x-ray dye) and/or removal of fluid. It may be necessary to make more than one pass of the needle to achieve the proper location. Depending on your condition, a drainage tube may be placed, a tissue sample taken or material injected through the needle. The specific procedure planned for your condition is:

_____

RISKS:

Risks associated with the procedure include pain or discomfort at the needle insertion site, bleeding at the site, injury to a blood vessel, organ puncture, infection which may result in an infection of the blood stream, the development of a blood clot (embolization), and stroke. Risks associated with the x-ray contrast material include an allergic reaction and reduced kidney function. The medications used for the conscious sedation are associated with the risks of aspiration (inhaling food or liquid into your lungs) or respiratory depression. In addition to these potential risks associated with the procedure, the x-ray contrast material, and the conscious sedation medications, there may be other unpredictable risks including death.

ALTERNATIVES:

There may be other procedures that can be performed to further evaluate and/or treat your condition. If you are unsure about having this procedure performed, please discuss these other alternatives with your physician.

AGREEMENT:

The information on this form was explained to me by _____. I understand the information and I have had the opportunity to ask my physician any other questions I might have about the procedure, the reasons it is being performed, the associated risks, and the alternatives to the procedure. I have voluntarily agree to have the procedure performed and accept the risks. I agree that if deemed necessary that submission of tissues may be made to a laboratory for diagnostic analysis. In addition, I am aware that no guarantee or assurance has been made as to the results of this procedure.

Patient Signature: _____ Date and Time: _____

Physician Signature: _____ Date and Time: _____

Witness Signature: _____ Date and Time: _____

The following to be used if the patient is a minor, unconscious, or otherwise lacking decision making capacity:

I, _____, the _____ of _____ hereby give consent.

Relative, Surrogate, or Guardian Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Witness to Telephone Consent Signature: _____ Date: _____

ADVANCED IMAGING CENTER, INC.

CONSENT TO MEDICAL OR SURGICAL CARE AND TREATMENT

NOTE TO PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment.

I authorize Dr. Ray Hashemi, M.D. and such physicians, associates, assistants and other personnel or the hospital or medical facility chosen by him or her to perform the following (IN MEDICAL TERMS KNOWN AS):

_____

_____

_____

(IN COMMON TERMS KNOWN AS)

_____

_____

_____

and/or to do any other procedures that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to remedy conditions discovered during the above procedure.

• **GENERAL RISKS AND COMPLICATIONS.** I am satisfied with my understanding or the more common risks and complications of the treatment or procedure which are described generally on the back of this form. These risks include the risk of bleeding, infection, pain, anesthesia risks and death.

• **SPECIFIC RISKS AND COMPLICATIONS.** I am satisfied with my understanding of specific risks of this procedure or treatment including (Doctor to describe specific risks where applicable):

_____

_____

_____

• **ALTERNATIVE METHODS OF TREATMENT.** I am satisfied with my understanding of alternative procedures or treatments and their possible benefits and risks including (Doctor to describe specific alternative procedures and complications where applicable):

_____

_____

_____

• **NO TREATMENT.** I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.

• **SECOND OPINION.** I have been offered the opportunity to seek a second opinion concerning the proposed treatment or procedure.

• **ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT.** I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.

• **OTHER SERVICES.** I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue or member in accordance with customary hospital or medical facility practice.

• **PHOTOGRAPHY.** I consent to the photographing, filming or videotaping of the treatment or procedure for educational or diagnostic use.

• **NO GUARANTEES.** I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.

• **OTHER QUESTIONS.** I am satistied with my understanding of the nature of the procedure or treatments and all of my additional questions about the treatment or procedure have been answered.

I have read and been given a copy of this form.

DATE _____ TIME _____ AM/PM

PRINT PATIENT NAME: _____

SIGNATURE: _____

(PATIENT, PARENT OR LEGAL GUARDIAN)

TRANSLATED BY (IF APPLICABLE): _____

PHYSICIAN: _____

WITNESS: _____

Advanced Imaging Center

Patient Name: _____

Informed Consent for Oral Sedation

Valium (diazepam) is a medication that can greatly minimize anxiety and stress that may be associated with claustrophobia. Even though it is safe, effective, and wears off after the MRI visit, you should be aware of some important precautions and considerations:

1. This consent form and all other paperwork should be signed before you take the medication.

2. The onset of diazepam is about 15 to 30 minutes. Do not drive after you have taken the medication. The peak effect occurs between 1 and 2 hours. After that, it starts wearing off and most people feel normal after 6 to 8 hours. For safety reasons and because people react differently, you should not drive or operate machinery the remainder of the day. Wait until tomorrow.

3. You must have someone drive you to and from your appointment. If you cannot arrange a ride, you cannot take the medications, no exceptions.

4. This medication should not be used if:

   a. you are hypersensitive to benzodiazepines (Xanax, Ativan, Versed, Halcion, etc.)
   b. you are pregnant or breast feeding
   c. you have liver or kidney disease
   d. you have a history of drug and/or alcohol abuse

5. Tell the doctor if you are taking any medications–either by prescription or over-the-counter. Of course, taking recreational/illicit drugs can also cause unwanted and unexpected reactions.

6. Side effects may include light-headedness, headache, dizziness, visual disturbances, amnesia, and nausea. In some people, oral diazepam may not work as desired.

7. You should not eat heavily prior to your appointment. You may take the medication with a small amount of food, such as juice, toast, etc. Taking it with too much food can make absorption into your system unpredictable.

8. On the way home from the office, your seat in the car should be in the reclined position. When at home, lie down with your head slightly elevated. Someone should stay with you for the next several hours because of possible disorientation and possible injury from falling.

I understand these considerations and am willing to abide by the conditions stated above. I have had an opportunity to ask questions and have had them answered to my satisfaction.

Dated:

_____ _____

Patient Witness

_____

AIC Representative

Advanced Imaging Center

PATIENT INFORMATION SHEET (IF UNDER 18 MUST BE COMPLETED BY PARENT/GUARDIAN)

Name: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip: _____ Sex: ____

Home Phone: _____ Cell Phone: _____ SSN:

Employer: _____ Phone: ( ) -

RESPONSIBLE PARTY

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

ABOUT YOUR CONDITION

Reason For Scan (Check One) Illness ___ Auto Accident ___ Job Injury ___

Date Of Illness/Auto Accident/Job Injury _____

Attorney's Name: _____ Phone: _____

Address: _____ City: _____ State: _____

PRIMARY INSURANCE INFORMATION

Name: _____ ID#: _____

Group/Policy #: _____ Phone: _____

Insured: _____ DOB: _____ Relationship: _____

SECONDARY INSURANCE INFORMATION

Name: _____ ID#: _____

Group/Policy #: _____ Phone: _____

Insured: _____ DOB: _____ Relationship: _____

It is understood and agreed that I the patient and/or responsible party (if minor) acknowledge and accept full responsibility for the charges for services rendered at Advanced Imaging Center. I also authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier of services rendered.

AIC makes every attempt to collect payment from insurance provider(s) prior to billing patients, but I understand that I am responsible for all co-pays, deductibles, non-covered services, and denied claims including, but not limited to, medical necessity.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Advanced Imaging Center

PATIENT MEDICAL HISTORY SHEET

Office Use Only

Ins. _____

Patient ID: _____ Scanner: _____ Date: _____

Scan(s): _____

Patient Name: _____ DOB: _____

Height: ' " Age: _____ Weight: _____ Sex: M__ F__

Referring Physician: _____ Follow-up appt. date with your physician: _____

Please specify the name(s) of any other doctor(s) you want the reports to go to: _____

Claustrophobic? Yes _ No _ Pregnant? Yes _ No _ Not Sure _ Allergies: _____

Please briefly describe your chief complaint, symptoms, and any surgeries on the part being scanned: _____

_____

Do you have pain? No _ Yes _ Where? _____

Have you had any injuries, trauma, accidents including auto accidents? No__ Yes__ If yes, Date of injury: _____

Type of injury: _____

Attorney's Name (if applicable): _____

Please list all previous surgeries (types and approximate dates): _____

_____

Are you a current or previous smoker? No _ Yes _ How many years? _____ How many packs per day? _____

Have you ever had cancer? No__ Yes__ What type? _____

Have you ever had chemotherapy? No__ Yes__ For what and when? _____

Have you ever had radiation therapy? No__ Yes__ For what and when? _____

Do you have any other medical conditions/disease? No__ Yes__; If yes, please explain: _____

_____

Briefly list all previous imaging studies (x-rays, MRI, CT, ultrasound, nuclear medicine, etc.) relating to today's scan with location and approximate date: _____

How did you hear about Advanced Imaging Center? _____

Patient's Signature: Date: _____

Please give us your feedback by filling out the patient satisfaction survey questionnaire before you leave the facility. Thank you for your patronage.