LONGHORN IMAGING

Patient Medical History Form

Patient Name:_____ DOB:_____
How did you hear about Longhorn Imaging? _____

Please take the time to fill this out accurately and completely. The answers you provide on this form assist the Radiologist to make an accurate & detailed diagnosis.

1. Details of symptoms/area of pain (please provide as much detail as possible)
   _____
   _____
2. How long have you been experiencing pain/symptoms? (please provide date of injury/accident if applicable)_____
3. Does the pain radiate, if so where does it radiate to?_____
   _____
4. What action causes the pain? (Standing / Bending / Sitting / Laying / Other) If other, please explain:
   _____
5. If you are here for your lower back do you have any of the following:
   Issues walking Yes / No
   Issues with bowel/bladder Yes / No
   If yes, please explain symptoms in detail: _____
   _____
6. If you are here for your neck do you have clumsiness in your hands? **Yes/No**
   If yes, please explain symptoms in detail: _____
   _____
7. Do you suffer from any of the following:
   Headaches **Yes / No**
   Blurred Vision **Yes / No**
   Dizziness **Yes / No**
   Poor Balance **Yes / No**
   Seizures **Yes / No**
   If you answered yes to any of these please explain symptoms in detail: _____
   _____
8. Do you have a history of cancer? **Yes / No**
   If yes, what type?_____
   Treatment performed:_____
9. Have you had prior image for the **SAME ISSUE** that you are being seen for today?
   Yes / No
   If yes, name of Imaging facility:_____
   If yes, did you bring your prior Imaging study with you today? **Yes / No**

Please list all surgeries/implants:

1. _____ 2. _____
3. _____ 4. _____