Radiology Associates
of the Fox Valley
333 N. Commercial Street, Neenah, WI

Patient Information Form (PIF) for Back Pain

The following patient information forms “Lumbar Spine” and “Thoracic Spine” are for patients undergoing radiography, computed tomography (CT), or magnetic resonance imaging (MRI) for back pain.

These patient information forms are also available individually at the company web page (www.foxvalleyradiology.com) under the “Protocols, Worksheets, & Templates” tab (as listed at the bottom of each form).

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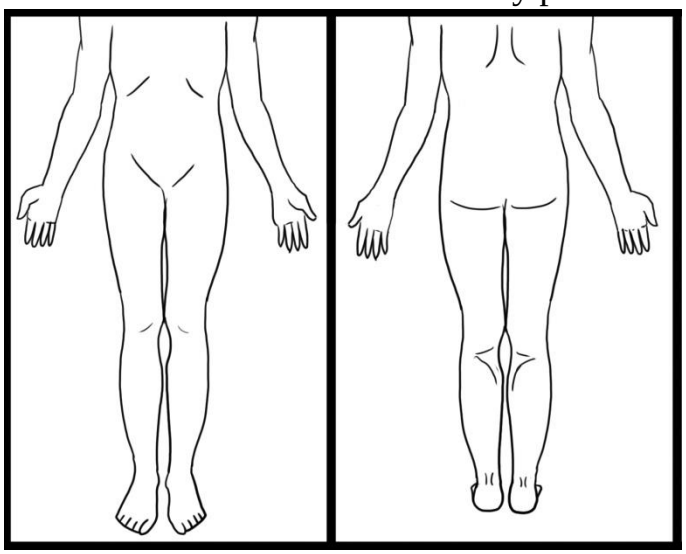
Patient Name: _____ Previous exam: _____
Date of birth: _____ Patient pregnant: YES NO
Medical Record #: _____ Patient breastfeeding: YES NO

Lumbar Spine

Please mark the location of any pain:



How long have you had your symptoms?
Have you had prior surgery done on the lumbar spine? If so, please tell us the approximate date(s) and procedure(s), whether the pain was better after the surgery, and if the pain you have now is the same as before your surgery:

If your pain is from an injury, please tell us the date of the injury describe what happened:

Please put a check if you have any of the following:	
	Buttock, hip, leg or foot weakness.
	Buttock, hip, leg or foot numbness.
	Pain which is worse with motion and relieved by rest.
	Arthritis in multiple joints in my body.
	A change in bowel or bladder habits.

Have you ever been diagnosed with cancer? YES NO
If yes, what type? _____

FOR TECHNOLOGIST USE ONLY (Fluoro time: ____ sec)

Call result?	No Yes	If "Yes", provider name/number:
Known follow-up appointment?	No Yes	If "Yes" indicate date/time and provider:
For CT and MR studies		
Was IV contrast injected?	No Yes	If "Yes": _____ mL of _____ (contrast type)
Hydration protocol?	No Yes	If "Yes", provide details:
Patient premedicated for contrast?	No Yes	If "Yes", provide details:
Abnormal response to contrast?	No Yes	If "Yes", provide details:

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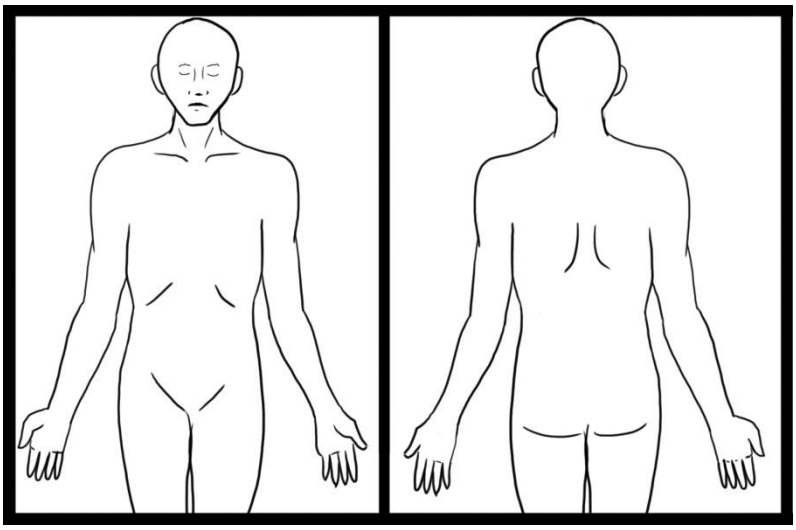
Patient Name: _____ Previous exam: _____
Date of birth: _____ Patient pregnant: YES NO
Medical Record #: _____ Patient breastfeeding: YES NO

Thoracic Spine

Please mark where your pain is:



How long have you had your symptoms?

Have you had prior surgery done on the spine? If so, please tell us the approximate date(s) and procedure(s), whether the pain was better after the surgery, and if the pain you have now is the same as before your surgery:

If your pain is from an injury, please tell us the date of the injury describe what happened:

Please put a check if you have any of the following:	
	Shoulder, arm, or hand weakness with my neck and/or back pain.
	Sshoulder, arm, or hand numbness with my neck and/or back pain.
	Pain which is worse with motion and relieved by rest.
	Arthritis in multiple joints in my body.
	Chest or jaw pain with my neck and/or back pain.
	A change in bladder or bowel habits with my neck and/or back pain.

Have you ever been diagnosed with cancer? YES NO
If yes, what type? _____

FOR TECHNOLOGIST USE ONLY (Fluoro time: ____ sec)

Call result?	No Yes	If "Yes", provider name/number:
Known follow-up appointment?	No Yes	If "Yes" indicate date/time and provider:
For CT and MR studies		
Was IV contrast injected?	No Yes	If "Yes": _____ mL of _____ (contrast type)
Hydration protocol?	No Yes	If "Yes", provide details:
Patient premedicated for contrast?	No Yes	If "Yes", provide details:
Abnormal response to contrast?	No Yes	If "Yes", provide details: