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

Patient Information Form (PIF) for Foot Symptoms

The following patient information forms are used for patients undergoing imaging of the foot.

The forms, titled “Right Foot” and “Left Foot” , are used for radiographs, computed tomography (CT), and magnetic resonance imaging (MRI) examinations.

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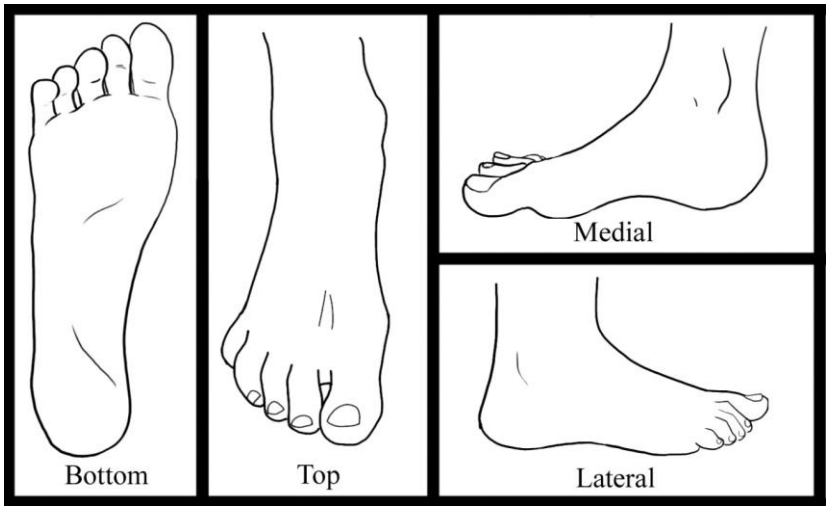
Patient Name: _____ Previous exam: _____
Date of birth: _____ Patient pregnant: YES NO
Medical Record #: _____ Patient breastfeeding: YES NO

Right Foot

Please mark the location of any pain:



How long have you had your symptoms?
Have you had prior surgery done on the foot? If so, please tell us the approximate date(s) and procedure(s):

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:	
	Back or leg pain with my foot pain.
	Pain when I move my foot.
	Pain which is worse with motion and relieved by rest.
	A sensation of foot joint instability.
	Arthritis in multiple joints in my body.

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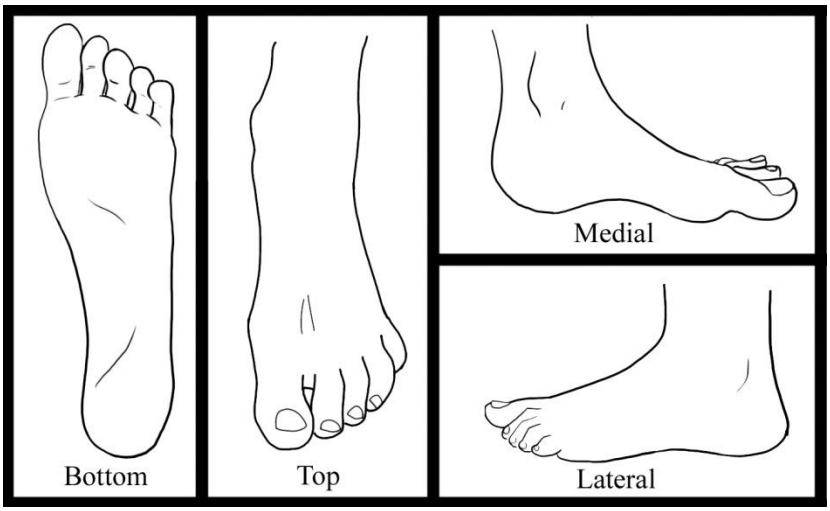
Patient Name: _____ Previous exam: _____
Date of birth: _____ Patient pregnant: YES NO
Medical Record #: _____ Patient breastfeeding: YES NO

Left Foot

Please mark the location of any pain:



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