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

Patient Information Form (PIF) for Face and Sinus Symptoms

The following patient information form "Face/Sinuses" is used for patients having radiography, computed tomography (CT), or magnetic resonance imaging (MRI) of the face/sinuses.

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

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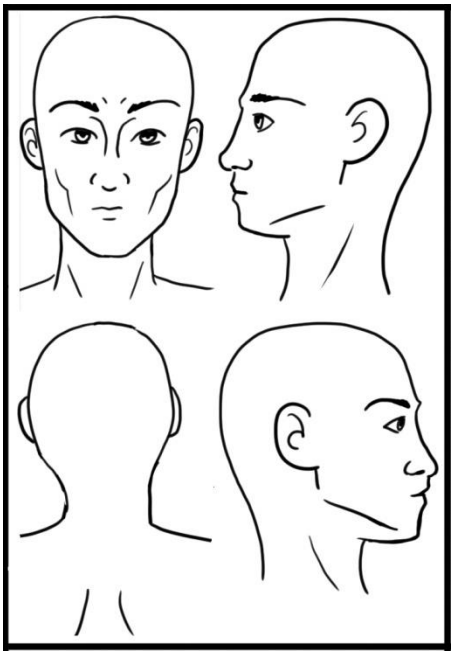
Face/Sinuses

Please mark the location of any pain:



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

Please check if you have any of the following:	
	Nasal congestion.
	Nose/throat drainage.
	Routine use of nasal inhalers.
	Routine use of oral decongestants.
	Current use of antibiotics.
	Blurred vision. Left eye, right, eye, both.
	Ringing in the ears. Left ear, right ear, both.
	TMJ joint clicking, locking, or pain.

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

Headache patients, please check all that apply (pick one column):

	NEW OR DIFFERENT HEADACHE		**RECURRENT/REPEATED HEADACHE**
	This is the worst headache I've ever had.		Light or sound makes my headaches worse.
	This is the first headache I've ever had.		My headaches get worse with physical activity
	My neck feels stiff.		My headaches have a throbbing quality.
	Headaches which change with posture.		My headaches only involve one side of my head.

For those with recurrent/repeated headache, how long do your headaches usually last? _____

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: