

DR DE VILLIERS AND PARTNERS INC
DIAGNOSTIC RADIOLOGISTS / DIAGNOSTIESE RADIOLOË

PR. NO. 3802590
Reg. No. 2012/037745/21

MRI / CT / IVP

PATIENT MEDICAL QUESTIONNAIRE

PATIENT SURNAME:..... FIRST NAMES:.....

D.O.B:..... WHEN DID YOU LAST EAT OR DRINK?:.....

PLEASE ANSWER THE QUESTIONS AND MARK WITH AN X.

**DO YOU SUFFER FROM ANY OF THE
FOLLOWING CONDITIONS?**

- | | | | |
|--|--|-----|----|
| 1. Cardiac / Heart condition? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |
| 2. Respiratory / Chest condition? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |
| 3. Neurological condition? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |
| 4. Renal / Kidney condition? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |
| 5. Are you Diabetic? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |
| 6. Do you take Insulin or oral
Antidiabetic Agents? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |
| 7. Are you on
Metformin / Glucophage? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |
| 8. Are you on Chronic Medication? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |

If yes, please name.....
.....

- | | | | |
|--------------------------------------|--|-----|----|
| 9. Do you suffer from any allergies? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |

If yes, please name.....
.....

**DO YOU HAVE ANY OF THE
FOLLOWING ?**

- | | | | |
|--|--|-----|----|
| 1. Pacemaker? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |
| 2. Aneurysm clip? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |
| 3. Artificial Heart Valve? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |
| 4. Vena cava filter? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |
| 5. Prosthesis (eg. Eye, breast. etc)? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |
| 6. Cochlear implant? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |
| 7. Shrapnel in eye or body? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |
| 8. Neurostimulator? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |
| 9. Any other implant (eg. screws
plates, joint replacements etc.) | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |

If yes, please name.....
.....

- | | | | |
|-----------------------|--|-----|----|
| 10. Are you pregnant? | <table border="1"><tr><td>YES</td><td>NO</td></tr></table> | YES | NO |
| YES | NO | | |

If you are anxious, claustrophobic, or in severe pain, oral, or intravenous sedation or analgesia may be required.
If either of the above is required, please note that you will be unable to drive a motor vehicle, operate machinery or sign legal documents for 12 hours following the sedation. You may, therefore, need to reschedule your appointment so that you can be accompanied by another person who can drive you home after the procedure.

I acknowledge that the potential risks of the examination have been explained to me and that during the course of the investigation, it may be necessary for the intravenous injection of contrast, analgesia or a sedative.

NAME:..... DATE:.....

SIGNED:.....

WITNESS SIGNATURE:..... NAME:.....

ATTENTION: It is the policy of this institution not to discuss the results of CT and MRI scans with patient for ethical reasons. All enquiries in this regard should be referred to the referring physician.