RADIOLOGIE ZENTRUM
SCHWABMÜNCHEN

Anamnesebogen Englisch

Questions regarding the examination procedure

Are you pregnant or is there a possibility that you could be pregnant? ☐ Yes ☐ No

I have previously undergone

- examinations involving X-rays or radioactive substances (X-ray, CT, nuclear medicine). When? _____ ☐ Yes ☐ No
- magnetic resonance imaging (MRI). When? _____ ☐ Yes ☐ No

I possess an X-ray record or past medical records. ☐ Yes ☐ No

Do you wear a pacemaker? ☐ Yes ☐ No

Do you wear any other electronic devices? ☐ Yes ☐ No
(e. g. ear implant, analgesia pump, hearing aid...)

Do you have implants or other metal parts in your body? ☐ Yes ☐ No
(e. g. artificial joints, screws, wire, splint, stent/bypass...)

If so, what? _____ Since when? _____

Anm

Questions regarding contrast agents

Did you ever have a negative reaction to a contrast agent? ☐ Yes ☐ No

If so, which reaction? ☐ vomiting ☐ nausea ☐ rash ☐ flush
☐ tingling sensation ☐ shock ☐ dizziness ☐ others: _____

During which examination/contrast agent? _____ ☐ Yes ☐ No

Do you have allergies or intolerances? If so, which one? _____ ☐ Yes ☐ No

Do you have a thyroid disorder? _____ ☐ Yes ☐ No

If so, which medication? _____

Relevant information (for MRI examiniations - due to examination in the magnetic field)

Do you wear removable electronic devices? (Hearing aid, smart watch, diabetes sensor, pain pump) These devices can heat up in the magnetic field, burn your skin and break. They must therefore be removed before the examination. ☐ Yes ☐ No

Do you wear a coil? ☐ Yes ☐ No
Please check with your gynecologist if your coil is still in place after this examination.

Did you get a tattoo within the last 6 weeks? ☐ Yes ☐ No
CAUTION! Tattoos and piercings can cause burns and health hazards.

Patient statement (please check the boxes if the applicable)

I declare that I have provided all information truthfully and completely. I understand that false or missing information may pose a health risk, and I accept liability for any resulting consequences. I have read and understood the MRI and/or CT information sheet, including the information on contrast agent administration. I have no further questions and consent to the examination.

I agree to the possible use of contrast agent ☐ Yes ☐ No
Contrast agent will only be used if there is a medical indication for it.

I agree to the transfer of images and results to the online portal (Praxisportal) ☐ Yes ☐ No
You will receive a QR code to our online portal, in which you can access your images and results for three month. You will only receive a CD with your images on explicit request and against invoice.

I agree to the transfer of the results to my general physician ☐ Yes ☐ No

General physician: _____

Further physicians to be informed of the results: _____

city, date

signature of the patient
and/or their guardian or caretaker

Vorb.	Gerät
Auto	KM

GFR:
TSH:

- ☐ IGeL
- ☐ CD extra
- ☐ no food
- ☐ drink
- ☐ premedication
- ☐ premliminary findings

General questions

height and weight ☐ **cm** ☐ **kg**

What is your profession? _____ Physical activities _____

Do you have one of the following diseases? If so, please tick the box:

☐ kidney disease ☐ thyroid disease ☐ diabetes ☐ high blood pressure ☐ HIV/hepatitis
☐ pulmonary disease ☐ rheumatism ☐ gout ☐ cardiovascular disease ☐ others

Do you take any medication? If so, which? _____ ☐ Yes ☐ No

Do you have unusual weightloss? ☐ Yes ☐ No

If so, when? _____ How much? _____ In which period? _____

Do you or did you have a tumor? ☐ Yes ☐ No

If so, since when? _____ Which tumor? _____

Which treatment? ☐ chemotherapy ☐ radiotherapy ☐ surgery ☐ others _____

Did you undergo any operations? If so, which one(s)?

☐ appendix ☐ gall bladder ☐ lower abdomen (women) ☐ prostate (men) ☐ others _____

Do you smoke? ☐ Yes ☐ No How much? _____ How long already? _____

Questions regarding the reason of this examination (please also fill in for regular check-ups)

Since when do you have discomfort? date _____ time period _____

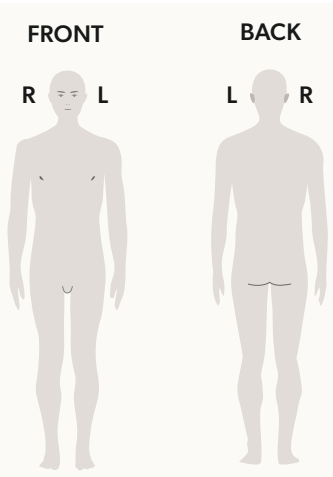
Is there a reason for the discomfort? (e. g. accident) ☐ Yes ☐ No

If so, what and how did it happen? _____

When do you feel discomfort?

☐ always, even at rest ☐ occasionally, for no apparent reason
☐ after physical stress ☐ after certain movements:

Please describe your discomfort as detailed as possible:



Mark the area with discomfort as precisely as possible in the sketch.

Did you already undergo any surgery or other treatments in this area? ☐ Yes ☐ No

If so, when? _____ What? _____ Which treatment? _____

Did you have previous discomfort, injury or diseases in this area? ☐ Yes ☐ No

If so, when? _____ Which one? _____

Which treatment? _____