ABERCROMIE RADIOLOGICAL CONSULTANTS, INC.

Special Procedures Questionnaire

Date:_____ ID#_____

Patient Name:_____ DOB:_____

Referring Physician:_____

Procedure requested:

Breast Biopsy	MRI Breast Biopsy	Block	Myelogram
Steroid Injection	Arthrogram	Epidural	Breast Localization

Are you taking any of the following medications?

Aspirin	Yes_____	No_____	Name of Medication_____
Anti-Inflammatory	Yes_____	No_____	Name of Medication_____
Blood Thinners	Yes_____	No_____	Name of Medication_____
Arthritis Medication	Yes_____	No_____	Name of Medication_____
Pain Medication	Yes_____	No_____	Name of Medication_____

Are you allergic to Latex, Lidocaine or Betadine? Yes_____ No_____

Are you allergic to any other medications? Yes_____ No_____

If yes, please list the medications: _____

_____

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