Diagnostic Outpatient Imaging

DATE: ______________ WEIGHT: ____________ AGE: ____________
PATIENT: ____ DOB: ______________
REFERRING PHYSICIAN: ____________________________
Tobacco use (# of years): ________ Alcohol Dependence: Yes ☐ No ☐
Prior Blood Transfusions: Yes ☐ No ☐ Number of Children: ______ Are you Pregnant? Yes ☐ No ☐

HAVE YOU EVER HAD A MRI SCAN? Yes ☐ No ☐ WHERE? ____________________
HAVE YOU EVER HAD A CT SCAN? Yes ☐ No ☐ WHERE? ____________________
HAVE YOU EVER HAD AN ULTRASOUND? Yes ☐ No ☐ WHERE? ____________________

SURGERIES:

☐ Gallbladder ☐ Appendix ☐ Uterus (Hysterectomy) ☐ Ovaries
☐ Tubal Ligation ☐ Aortic Aneurysm ☐ Cervical Spine ☐ Lumbar spine
☐ Prostate ☐ Sinus ☐ Hernia repair ☐ Heart

Other Surgeries:
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DRUG ALLERGIES:

☐ Gadolinium (MRI Contrast) ☐ IV Contrast/Iodine for CT or X-ray ☐ Penicillin
☐ Sulfa Drugs Other: ____________________

CONDITIONS:

☐ Heart Pacemaker ☐ AIDS ☐ Alcoholism ☐ Anemia
☐ Asthma ☐ Appendicitis ☐ Aneurysm Clips ☐ Bleeding Disorder
☐ Bronchitis ☐ Bullets/ BB's ☐ Cancer (specify) ____________________
☐ Chemical Dependency ☐ Dental Fillings ☐ Diabetes (Glucophage) Yes ____ No ____
☐ Emphysema ☐ Epilepsy ☐ False Eye/Ocular Implants
☐ Goiter ☐ Gout ☐ Heart Disease ☐ Hepatitis
☐ Hernia ☐ High Cholesterol ☐ Hearing Aid ☐ High Blood Pressure
☐ Inner Ear Tubes ☐ I.U.D. ☐ Insulin Infusion Pump ☐ Kidney Disease
☐ Liver Disease ☐ Mononucleosis ☐ Multiple Sclerosis ☐ Nerve or Bio Stimulators
☐ Orthopedic screws, rods or plates ☐ Pneumonia ☐ Porta Cath(Chemo)
☐ Permanent Eyeliner, Tatoos ☐ Removable Dentures ☐ Stroke
☐ Thyroid Problems ☐ Tuberculosis ☐ Ulcers
☐ Other: ____________________

REASON FOR EXAMS/SYMPTOMS: ____________________
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I, ______________________________, VERIFY THAT ALL THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

NOTE: ____________________