

IMAGING HEALTH QUESTIONNAIRE

Patient name: _____

Form completed by (if different than patient): _____

Age: _____ Sex: _____ DOB: ____/____/____ Ht. _____ Wt. _____

Describe your **symptoms**: _____

How long have you had this problem? _____

If you are having pain where is the pain **predominant**? _____

Were you injured? Yes _____ No _____ If yes, how? _____

Have you had surgery on the body part being examined? Yes _____ No _____ If yes, what type of Surgery was done? _____ Date: _____

List other surgeries (include dates): _____

Have you had the following diagnostic tests? (Problem area only)

CAT Scan	Yes _____	No _____	Where: _____	When: _____
MRI	Yes _____	No _____	Where: _____	When: _____
Nuclear tests	Yes _____	No _____	Where: _____	When: _____
Ultrasound	Yes _____	No _____	Where: _____	When: _____
X-rays	Yes _____	No _____	Where: _____	When: _____

List all medications that you are **currently** taking: _____

Do you have any allergies to food/medication? Yes _____ No _____ List: _____

Do you have a sensitivity/allergy to iodine? Yes _____ No _____ Have you ever had Iodine contrast before? Yes _____ No _____ When: _____

Have you ever had?	Yes	No	Have you ever had?	Yes	No
Diabetes			Asthma/Respiratory problems?		
Hypertension/Cardiac Problems			Emphysema		
Elevated Cholesterol			Seizures		
Liver Disease			Cancer		
Urinary/Kidney Problems			Family History of any listed?		
Women Only: Are you pregnant?			Date of LMP:		
Are you breast-feeding?			Date of surgical sterilization:		

Are you a smoker? Yes _____ No _____ If yes, how many years _____

Do you currently or have you ever had any type of cancer? Yes _____ No _____ List the type of cancer and treatment type if applicable: _____

Patient Signature _____ Date _____