Patient Questionnaire

Patient Name: _____ Date of Birth: _____ Referring Physician: _____

Body Part to be examined:

☐ Abdomen	☐ Cervical Spine/Neck	Foot	☐ Right ☐ Left	Lower Leg	☐ Right ☐ Left
☐ Brain	☐ Thoracic Spine	Forearm	☐ Right ☐ Left	Shoulder	☐ Right ☐ Left
☐ Chest	☐ Lumbar Spine	Hand	☐ Right ☐ Left	Thigh	☐ Right ☐ Left
☐ Jaw	Ankle ☐ Right ☐ Left	Hip	☐ Right ☐ Left	Wrist	☐ Right ☐ Left
☐ Pelvis	Elbow ☐ Right ☐ Left	Knee	☐ Right ☐ Left	Other	_____

Explain your medical problems that are the reason for having this MRI/CT/Ultrasound/X-Ray _____

How long have you had this problem? _____

Have you had a recent injury/trauma to this area? _____

Have you had prior imaging studies on the area of interest? If so, what type of scan and dates of scan? _____

List all other medical problems _____

List previous surgeries and dates of surgery to the area of concern _____

Specify if you have had any previous physical/conservative therapy _____

Specify if you have been treated for any medical illness or disease _____

Please check the box if you have a history or currently have any of the following:

☐ Diabetes	☐ Multiple Myeloma	☐ Sino Arterial Dysfunction	☐ Dizziness
☐ Kidney Failure	☐ Cancer	☐ Heart Attack	☐ Seizures
☐ Renal Disease	☐ Chemotherapy or Radiation	☐ Heart Disease	☐ Memory Loss
☐ Renal Surgery	☐ Heart Block	☐ High Blood Pressure	☐ Hearing Loss ☐ Right ☐ Left
☐ Sickle Cell Anemia	☐ Ventricular Tachycardia	☐ Headaches	☐ Asthma/Hay Fever
☐ Pain/Numbness/Weakness in Upper Extremity ☐ Right ☐ Left			☐ Severe Debilitation
☐ Pain/Numbness/Weakness in Lower Extremity ☐ Right ☐ Left			☐ HIV/Hepatitis

MRI/CT ONLY: Do you have any of the following items in your body?

☐ Yes	☐ No	Pacemaker/Wires/Defibrillator	☐ Yes	☐ No	Body Piercing
☐ Yes	☐ No	Brain Aneurysm Clip	☐ Yes	☐ No	Ear Implant
☐ Yes	☐ No	Eye Implant/Metal in Eyes	☐ Yes	☐ No	Electrical Nerve Stimulator
☐ Yes	☐ No	Bullets/BBs/Pellets	☐ Yes	☐ No	Metal Implants
☐ Yes	☐ No	Coil/Filter/Stents in Blood Vessels	☐ Yes	☐ No	Artificial Limb/Joint
☐ Yes	☐ No	Permanent Tattoos	☐ Yes	☐ No	Implanted Catheter/Tube
☐ Yes	☐ No	Artificial Heart Valve	☐ Yes	☐ No	Penile Prosthesis
☐ Yes	☐ No	Shunt	☐ Yes	☐ No	False Teeth/Retainer/Magnetic Braces
☐ Yes	☐ No	Surgical Clips/Staples/Wires/Mesh/Stitches	☐ Yes	☐ No	Diaphragm/Intrauterine Devices
☐ Yes	☐ No	Plates/Screws/Pins/Rods	☐ Yes	☐ No	Bone Growth/Fusion Stimulator/Tissue Expander
☐ Yes	☐ No	Drug Infusion Pump			

****FEMALE PATIENTS ONLY****

Are you currently Pregnant or Breast Feeding? ☐ Yes ☐ No

When was the First Day of your last menstrual cycle? _____

Have you had intercourse since the first day of your last menstrual cycle? ☐ Yes ☐ No

If yes, are you using birth control or have had a hysterectomy/tubal ligation/uterine ablation? _____

I authorize Preferred Imaging/Premier Health Services to perform all diagnostic procedures that were ordered for me by my physician. I hereby release Preferred Imaging/Premier Health Services from any and all liability pertaining to the performance of diagnostic imaging procedures. Furthermore, I understand and agree that Preferred Imaging/Premier Health Services is released from all liability and litigation pertaining to myself, and/or my unborn child. I have been informed of the current risks to myself and to my unborn child (if pregnant) if exposed to radiation from a CT scan, X-Ray and/or IV & Oral contrast. While it is currently accepted that ultrasound and MRI are not proven to be harmful to an unborn child, if complications arise, I fully understand and agree to release Preferred Imaging/Premier Health Services from any and all liabilities.

Patient Signature: _____ Date: _____

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

I authorize full disclosure of my medical records to the following person: _____

Patient Signature: _____ Date: _____