

Patient Questionnaire

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

Body Part to be Examined Today:

<input type="checkbox"/> Abdomen	<input type="checkbox"/> Cervical Spine/Neck	Foot	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Lower Leg	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Brain	<input type="checkbox"/> Thoracic Spine	Forearm	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Shoulder	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Chest	<input type="checkbox"/> Lumbar Spine	Hand	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Thigh	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Jaw	Ankle		<input type="checkbox"/> Right	<input type="checkbox"/> Left	Wrist	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Pelvis	Elbow		<input type="checkbox"/> Right	<input type="checkbox"/> Left	Knee	<input type="checkbox"/> Right	<input type="checkbox"/> 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? _____

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 _____

Specify if you have any known allergies to medications _____

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

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Multiple Myeloma	<input type="checkbox"/> Sino Arterial Dysfunction	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Seizures
<input type="checkbox"/> Renal Disease	<input type="checkbox"/> Chemotherapy or Radiation	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Renal Surgery	<input type="checkbox"/> Heart Block	<input type="checkbox"/> Pulmonary Hypertension	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Ventricular Tachycardia	<input type="checkbox"/> Headaches	<input type="checkbox"/> Asthma/Hay Fever
<input type="checkbox"/> Pain/Numbness/Weakness in Upper Extremity <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Severe Debilitation	
<input type="checkbox"/> Pain/Numbness/Weakness in Lower Extremity <input type="checkbox"/> Right <input type="checkbox"/> Left		<input type="checkbox"/> HIV / Hepatitis _____	

MRI/CT ONLY: Do you have any of the following items in your body? Please mark Yes/No for every question.

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

****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: _____