Community Health Network

PATIENT IDENTIFICATION

MEDICAL IMAGING QUESTIONNAIRE

Medical History: Please check Yes or No

Y	N		Y	N	
☐	☐	Age 60 or older	☐	☐	History of Cancer
☐	☐	Diabetic	☐	☐	Taking hydroxyurea (Cancer Drug)
☐	☐	High Blood Pressure	☐	☐	Infectious Disease (Meningitis, Hepatitis, HIV, AIDS, TB)
☐	☐	Known Renal Disease or Renal Failure (Acute of Chronic)	☐	☐	Currently Pregnant or Chance of Pregnancy
☐	☐	Kidney problems (transplant, single kidney, kidney cancer, or kidney surgery, see a nephrologist (kidney doctor))	☐	☐	Allergic to Amiodarone (heart medication)
☐	☐	Severe Heart Failure (unable to carry out any physical activity without discomfort and unable to walk 10 yards)	☐	☐	Allergic to Furosemide (example: Lasix or water pill)
☐	☐	Lab work in the last 4 weeks	☐	☐	Allergic to Sulfa

Have you ever had an injection of IV contrast for a medical imaging exam? ☐ Y ☐ N

If yes, did you have a reaction? ☐ Y ☐ N

If yes, what kind of reaction did you have?_____

Drug or Food Allergies? ☐ Y ☐ N If yes, please list: _____

_____

What body part are we imaging today? (Circle) Head Neck Chest Abdomen Pelvis Extremity

Have you had this done before? ☐ Y ☐ N If Yes, where?_____

List any Surgeries or Trauma in the area being imaged:_____

Reason for Exam (Please list symptoms):_____

List all medications including Herbal supplements and vitamins (If you have a list, bring it to your appointment.)

Medication	Dosage	Medication	Dosage

Continued medication list on back.

Weight: _____ Height: _____

I certify that the above answers are true & correct based upon my knowledge & belief.

Patient Signature: _____ Date: _____ Time: _____

Technologist Signature: _____ Date: _____ Time: _____

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I certify that the above answers are true & correct based upon my knowledge & belief.

Patient Signature: _____ Date: _____ Time: _____

Technologist Signature: _____ Date: _____ Time: _____