Patient Medical Questionnaire

*Date:___/___/___*Name: _____*DOB:_____*Gender:___*Weight:_____

Describe your symptoms: _____

Was this due to an accident? _____ Date: _____
List all medications: _____

*List all allergies, including Iodine or Shellfish: _____
List all previous surgeries: _____

Have you ever had any of the following? (circle all that apply)

	Date	Facility	Body Part		Date	Facility	Body Part
CT Scan				MRI			
Myelo/ Discogram				PetScan/Bonescan			

Please check YES or NO to all of the following:

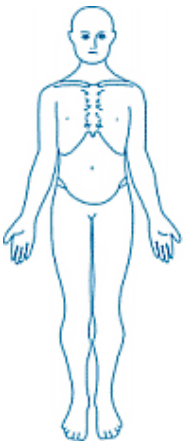
(all patients)	Yes	No	*(contrast patients only)	Yes	No
*Cardiac Pacemaker			*Are you age 55 or older?		
*Metal implants of any kind			*Do you have Diabetes or Hypertension?		
*Are you claustrophobic?			*Personal/ family history Of kidney problems?		
Ear/eye prosthesis					
Prosthetic valve			*Do you have Multiple Myeloma?		
Joint/hip replacement			*Collagen vascular disease? (Lupus, Rheumatoid Arthritis, Scleroderma?)		
Heart/ brain surgery					
Hearing aids					
Medical patches			*Any transplanted organs?		
Gunshot wound/shrapnel			*Blood work in the last 30 days?		
Tattoo/tattooed eyeliner					
Do you work as a welder?					

*Women only:
*Are you breast-feeding? _____
*Are you pregnant? _____
*Is there any chance that you may be pregnant?
_____
*Date of last normal menstrual cycle? _____

Is sedation scheduled? Yes No Self

Office Use Only
Diagnosis:
(Please circle) Pt taking: Film CD
Patient's initials:
Protocol
Tech Notes

Circle the symptom and shade the appropriate body part.



Ache

Pins and needles

Burning

Stabbing

Numbness

Tingling

Weakness

RT LT LT RT

When is your next follow up appointment with your referring doctor? _____

Patient/ Guardian Signature: _____