diagnostichealth

# PATIENT CONSOLIDATED HISTORY AND SCREENING FORM

***Patient Information*** Date:__________________

Patient Name: ______________________________ Sex: ☐ M ☐ F Weight:___________ Height:_________

Patient #:________________ DOB:____________ Age:_______ Procedure:________________________

Referring Physician:_____________ Are you pregnant? ☐Yes ☐No ☐N/A Date of last period:___________

Reason you are here today for an exam? **Explain your medical problem in detail.** (What is the problem? Where is the problem? How long have you had this problem?)________________________________________

________________________________________________________________________________

Have you had a previous imaging study related to this problem (x-ray, ultrasound, CT, MRI)? ☐ Yes ☐ No
If yes, please explain:
What exam?__________________________ When?_________________ Name of facility:_______________

List other medical problems:______________________________________________________________

List previous surgeries:__________________________________________________________________

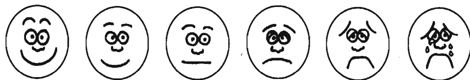
Medications you are presently taking:_______________________________________________________

List any drug/latex or food allergies:_______________________________________________________

Do you Smoke? ☐ Yes ☐ No If yes, # of years:____________ Packs per day: ____________

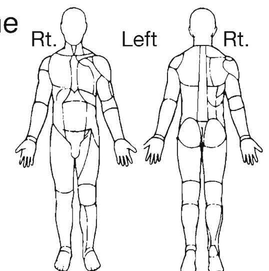
Do you have pain? ☐ Yes ☐ No ☐N/A

How long have you had pain?_____________
Pain Rating/Intensity:



1 2 3 4 5 6 7 8 9 10

Draw on the figures where the pain/symptoms are located:




***Contrast Exams Only*** ☐ ***Not Applicable***

Are you taking Metformin Hydrochloride (Glucophage, Glucovance, Avandemet, Metaglip, Fortamet)? ☐Yes ☐No

Have you ever had a previous allergic reaction to x-ray contrast (dye)? ☐Yes ☐No

If yes, explain: ________________________________________________________________

**Any personal history of:**

☐Yes ☐No Headaches
☐Yes ☐ No Liver Disease
☐Yes ☐No Diabetes
☐Yes ☐No Stroke
☐Yes ☐No Asthma
☐Yes ☐No Allergic Respiratory Disease
☐Yes ☐No Dizziness
☐Yes ☐No Are you breast feeding at this time?

☐Yes ☐No Kidney Disease/Kidney Failure
☐Yes ☐No Are you on Dialysis?
☐Yes ☐ No Bladder Disease
☐Yes ☐No Cancer
☐Yes ☐No Heart Disease
☐Yes ☐No Prostate Problems
☐Yes ☐No Seizure Disorder
☐Yes ☐No Multiple Myeloma
☐Yes ☐No Blood Disorder/Sickle Cell

If yes, please explain:_____________________________________________________________

________________________________________________________________________________

Comments:______________________________________________________________________

**** *FOR MRI ONLY* **** ☐ ***NOT APPLICABLE FOR THIS EXAM***

**WARNING: Certain implants and devices may be hazardous to you and/or may interfere with the MRI procedure. If you have any implants or devices, DO NOT ENTER the MRI room without discussing this with the MRI Technologist. The MR system magnet is ALWAYS on.**

Do you have any of the following?

☐ Yes ☐ No Heart Surgery/Heart Valve/Pacemaker. If yes, explain:__________

☐ Yes ☐ No Brain Surgery/Brain Aneurysm Clips. If yes, explain:__________

☐ Yes ☐ No Shunts/Stents/Intravascular Coil. If yes, explain:__________

☐ Yes ☐ No Eye Surgery/Implants. If yes, explain:__________

☐ Yes ☐ No Injury to eye involving metal or metal shavings. If yes, explain:__________

☐ Yes ☐ No Penile Prosthesis. If yes, explain:__________

☐ Yes ☐ No Orthopedic pins, screws, rods, etc. If yes, explain:__________

☐ Yes ☐ No Neurostimulator/Biostimulator. If yes, explain:__________

☐ Yes ☐ No Radiation Therapy/Chemo Therapy. If yes, explain:__________

☐ Yes ☐ No History of Cancer or Tumors. If yes, explain:__________

☐ Yes ☐ No Previous back surgery (neck/back). If yes, explain:__________

☐ Yes ☐ No Ear Surgery/Cochlear Implants/Hearing Aids. If yes, explain:__________

☐ Yes ☐ No Diaphragm/IUD/Pessary. If yes, explain:__________

☐ Yes ☐ No Metal mesh implants/wire sutures/wire staples/internal electrodes. If yes, explain:__________

☐ Yes ☐ No Any electrical, mechanical, or magnetic implants. If yes, type:__________

☐ Yes ☐ No Implanted drug infusion pump/insulin pump. If yes, explain:__________

☐ Yes ☐ No Implanted cardiac defibrillator. If yes, explain:__________

☐ Yes ☐ No Pacing wires, Swann GANZ Catheter __________

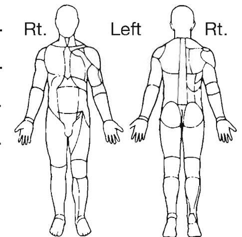
☐ Yes ☐ No Tattoos/Permanent make-up/Body piercings. If yes, explain:__________

☐ Yes ☐ No Dentures, partials, or dental implants. If yes, explain:__________

☐ Yes ☐ No Gunshot wounds, shrapnel, BBs. If yes, explain:__________

☐ Yes ☐ No Vascular Access Port. If yes, explain:__________

☐ Yes ☐ No Medication patch? If yes, explain: __________




**Draw on the figures the location of any metal in your body:**

***Acknowledgement:*** I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that I am not pregnant at this time. I give consent to the performance of a/an__________
at Diagnostic Health

| __________ | __________ | __________ |
|---|---|---|
| **Patient/Parent/Guardian Signature** | **Technologist/Witness Signature** | **Date** |

## *FOR CLINICAL USE ONLY*

Patient Education given: ☐Verbal ☐Brochure ☐Video Identify:__________

Patient Shielded: ☐Yes ☐No ☐N/A BUN ______ Creatinine______ ☐N/A

***CONTRAST ADMINISTRATION*** ☐ ***NOT APPLICABLE TO THIS EXAMINATION***

______CC of __________ with a __________@__________
Amount Type of Contrast Ga & needle type Time

X______ in__________ Lot # __________ Expiration date: __________
\# of punctures site location

Physician Covering Contrast: __________ By: __________
Signature

Power Injector used? ☐Yes ☐No Rate:______ cc per ______ seconds

Contrast Reaction
or Extravasation: ☐ Yes ☐ No Explain: __________

If additional space is needed for documentation, use patient notes form:

Discharge Instructions given? ☐ Yes ☐ No Form #: __________