Advanced Imaging Center

PATIENT MEDICAL HISTORY SHEET

Office Use Only

Insurance_____

Patient ID: _____ SCAN(s): _____ Scanner: _____ Date: _____

Patient Name: _____ DOB: _____ Age: ____ Sex: M__ F__ Weight: _____ Height: _____

Referring Physician: _____ Follow-up appt. date w/ your physician: _____

Please specify the name(s) of any other doctor(s) you want the reports to go to: _____

Claustrophobic? Yes __ No__ Pregnant? Yes__ No__ Not sure__ Allergies: _____

Please briefly describe your chief complaint, symptoms, and any surgeries on the area being scanned: _____

_____

Do you have pain? No__ Yes__ Where? _____

Have you had any injuries, trauma, or auto accidents? No__ Yes__ If yes, Date of injury: _____

Type of injury: _____

Attorney's Name (if applicable): _____

Please list all previous surgeries (locations and approximate dates): _____

_____

Are you a current or previous smoker? No__ Yes__ How many years? _____ How many packs per day? _____

Have you ever had cancer? No__ Yes__ What type? _____

Have you ever had chemotherapy? No__ Yes__ For what and when? _____

Have you ever had radiation therapy? No__ Yes__ For what and when? _____

Do you have any other medical conditions/disease? No__ Yes__ If yes, please explain: _____

_____

Briefly list all previous imaging studies (x-rays, MRI, CT, ultrasound, nuclear medicine, etc.) relating to today's scan with location and approximate date: _____

How did you hear about Advanced Imaging Center? _____

Please give us your feedback by filling out the patient satisfaction survey before leaving the facility.

Thank you for your patronage.