LENOX HILL RADIOLOGY & MEDICAL IMAGING ASSOCIATES P.C.

Name: ______________________________ DOB: __________ Age: ______ Sex: F M

Address: ______________________________

Mobile #: ______________________ Home #: ______________________

Email: ______________________________

Briefly state the reason for your exam and please include all symptoms you are experiencing:

____

____

Height: ________ Weight: ________ Do you know what your blood pressure usually is? ________

Do you have any allergies to any medications? If yes, please list:

____

Have you ever had a reaction to iodine contrast for CT scans? ☐ Y ☐ N

Have you ever had a reaction to gadolinium? ☐ Y ☐ N

Have you ever had an anaphylactic reaction to anything? ☐ Y ☐ N

List any medications you are currently taking: ______________________________

Do you wear any medication patches (e.g. pain medication, birth control, nicotine, etc.)?

Do you have any of the following medical conditions:

☐ Asthma ☐ COPD ☐ Diabetes ☐ Kidney disease

☐ Thyrotoxicosis ☐ Sickle cell/Hemolytic Anemia ☐ Multiple myeloma

☐ Pheochromocytoma ☐ Seizures ☐ Liver Disease Dialysis

Have you ever been diagnosed with cancer? If yes, please indicate type of cancer: ______________

Last chemotherapy treatment: ______________________________

Last radiation treatment: ______________________________

Please list all surgeries: ______________________________

____

Do you have a pacemaker? ☐ Y ☐ N Retinal Tack? ☐ Y ☐ N Aneurysm clips? ☐ Y ☐ N

Cochlear Implants? ☐ Y ☐ N Implant of any kind? ☐ Y ☐ N

Have you ever been injured by a metallic object or fragment (e.g. Metallic slivers, shavings, BB, bullet, shrapnel)? ☐ Y ☐ N

For Female Patients:

Are you pregnant? ☐ Y ☐ N Date of last menstrual period: ______________

Are you breastfeeding? ☐ Y ☐ N Age of onset of menopause: ______________

Are you taking oral contraceptives or hormonal treatment? ☐ Y ☐ N

Are you taking any type of fertility medication or having fertility treatment? ☐ Y ☐ N

Have you had a breast cancer screening? ☐ Y ☐ N Date of last mammogram:

The American Cancer Society recommends women over 40 have yearly screening mammogram, please see a front desk representative if you would like to schedule an exam.

Have you ever been a smoker? ☐ Yes ☐ currently ☐ No- Quit date: ______ ☐ Never smoked

Have you ever had a colorectal cancer screening? ☐ Y ☐ N

Date of colonoscopy: ______________________

Have you had an influenza vaccine? ☐ Y ☐ N

Have you had a pneumococcal vaccine? ☐ Y ☐ N

PATIENT SIGNATURE: **DATE:**