Park Avenue Radiologists, P.C.

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE

DIAGNOSTIC PROCEDURE QUESTIONNAIRE

PATIENT NAME: DOB: AGE:

Account Number: **SOCIAL SECURITY #:** FEMALE / MALE (PLEASE CIRCLE)

REFERRING PHYSICIAN/PHONE NUMBER:

IF YOU ARE PREGNANT, PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY.

ARE YOU OR COULD YOU BE PREGNANT? YES NO _______(INITIAL) DATE OF LAST MENSTRUAL CYCLE: _____/____/_________

ARE YOU CURRENTLY BREAST FEEDING? YES NO _______(INITIAL)

HAVE YOU HAD ANYTHING TO EAT IN THE LAST 3 HOURS? YES NO IF YES, WHAT TIME? ____________________

WHAT SYMPTOMS OR COMPLAINTS BROUGHT YOU HERE? ____

____

PLEASE SPECIFY THE LOCATION AND DURATION OF SYMPTOMS: ____

____

WHICH SIDE? RIGHT LEFT OTHER ____

DO YOU HAVE ANY ALLERGIES? YES NO IF YES, EXPLAIN ____

____

HAVE YOU HAD A CONTRAST DYE INJECTION BEFORE? YES NO

IF YES, DID YOU HAVE ANY PROBLEMS OR REACTION TO THIS INJECTION? YES NO

IF YES, PLEASE EXPLAIN ____

HAVE YOU BEEN MEDICATED FOR THIS PROCEDURE? YES NO TECH INITIALS ______________

PLEASE LIST ALL PRIOR SURGERIES:

[ ] NONE DATE

[ ] ____ _____/____/_________

[ ] ____ _____/____/_________

[ ] ____ _____/____/_________

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER OR SERIOUS ILLNESS? YES NO

IF YES, WHAT KIND? ____

IF YES, HAVE YOU HAD CHEMOTHERAPY? YES NO DATES: _____/____/_________

IF YES, HAVE YOU HAD RADIATION THERAPY? YES NO DATES: _____/____/_________

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

DO YOU HAVE ASTHMA? YES NO IF YES, ARE YOU CURRENTLY SYMPTOMATIC? YES NO

HIGH BLOOD PRESSURE? YES NO LUNG DISEASE? YES NO

SHORTNESS OF BREATH? YES NO HEART DISEASE? YES NO

KIDNEY DYSFUNCTION? YES NO

ARE YOU CURRENTLY ON DIALYSIS? YES NO IF YES, DATE OF NEXT SESSION ___/___/_____

ARE YOU OR HAVE YOU EVER BEEN A SMOKER? YES NO

IF YES, HOW MANY PACKS PER DAY? ____________

FOR HOW MANY YEARS? ________________________

ARE YOU A DIABETIC? YES NO IF YES, ARE YOU TAKING:

GLUCOPHAGE METFORMIN OR GLUCOVANCE

(PLEASE CIRCLE AND INITIAL)

I ATTEST THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

____ ____________________

SIGNATURE OF PATIENT OR GUARDIAN OR PERSON AUTHORIZED TO CONSENT FOR PATIENT DATE

AS PART OF THIS PROCEDURE I CONSENT TO HAVE INTRAVENOUS CONTRAST MATERIAL GIVEN TO ME. THIS INTRAVENOUS CONTRAST MATERIAL IS ADMINISTERED THROUGH A NEEDLE PLACED IN THE VEIN. THE INDICATIONS AND RISKS OF THIS PROCEDURE HAVE BEEN EXPLAINED TO ME. IT HAS ALSO BEEN EXPLAINED TO ME THAT THE POTENTIAL REACTIONS TO THE CONTRAST, WHILE RARE CAN INCLUDE ALLERGIC REACTION FROM MILD TO SEVERE SWELLING OR INFECTION OF THE INJECTION SITE, BLEEDING, DIFFICULTY BREATHING, LOW BLOOD PRESSURE AND KIDNEY DYSFUNCTION.

THERE ARE TWO TYPES OF CONTRAST AVAILABLE FOR USE FOR THIS TYPE OF EXAM: FOR THE SAFETY OF OUR PATIENTS WE USE ONLY THE NON-IONIC CONTRAST AGENT, WHICH IS LESS LIKELY TO PRODUCE REACTIONS.

____ ____________________

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TECHNOLOGIST NOTES:

TECH SIGNATURE