

MEDICAL IMAGING QUESTIONNAIRE
Medical History: Please check Yes or No

Y N	Y N
☐ ☐ Age 60 or older	☐ ☐ History of Cancer
☐ ☐ Diabetic	☐ ☐ Taking hydroxyurea (Cancer Drug)
☐ ☐ High Blood Pressure	☐ ☐ Infectious Disease (Meningitis, Hepatitis, HIV, AIDS, TB)
☐ ☐ Known Renal Disease or Renal Failure (Acute or Chronic)	☐ ☐ Currently Pregnant or Chance of Pregnancy
☐ ☐ Kidney problems (transplant, single kidney, kidney cancer, or kidney surgery, see a nephrologist (kidney doctor))	☐ ☐ Allergic to Amiodarone (heart medication)
☐ ☐ Severe Heart Failure (unable to carry out any physical activity without discomfort and unable to walk 10 yards)	☐ ☐ Allergic to Furosemide (example: Lasix or water pill)
☐ ☐ Lab work in the last 4 weeks	☐ ☐ Allergic to Sulfa

 Have you ever had an injection of IV contrast for a medical imaging exam? ☐ Y ☐ N

 If yes, did you have a reaction? ☐ Y ☐ N

If yes, what kind of reaction did you have? _____

 Drug or Food Allergies? ☐ Y ☐ N If yes, please list: _____

What body part are we imaging today? (Circle) Head Neck Chest Abdomen Pelvis Extremity

 Have you had this done before? ☐ Y ☐ N If Yes, where? _____

List any Surgeries or Trauma in the area being imaged: _____

Reason for Exam (Please list symptoms): _____

List all medications including Herbal supplements and vitamins (If you have a list, bring it to your appointment.)

Medication	Dosage	Medication	Dosage

Continued medication list on back.

Weight: _____ Height: _____

I certify that the above answers are true & correct based upon my knowledge & belief.

Patient Signature: _____ Date: _____ Time: _____

Technologist Signature: _____ Date: _____ Time: _____





**Community
Health Network**

PATIENT IDENTIFICATION

MEDICAL IMAGING QUESTIONNAIRE

[illegible]

I certify that the above answers are true & correct based upon my knowledge & belief.

Patient Signature: _____ Date: _____ Time: _____

Technologist Signature: _____ Date: _____ Time: _____

