SDMI STEINBERG DIAGNOSTIC

INTAKE QUESTIONNAIRE
SNIFF TEST

First Name _____ Last Name _____ DOB/Age _____

Allergies/Include reaction(s) _____

Height _____ Weight _____ Patient# (Internal use only) _____

REASON FOR EXAM *(Please include symptoms and time frame):*

TECH NOTES *(for internal use only)*:

Previous Imaging Studies Related to Todays Exam	Date

Previous Surgeries Related to Todays Exam	Date

Have you ever had any of the following procedures in the past (if yes, please indicate when):

Spine surgery ☐ **Yes** ☐ **No** _____ **Chest/abdominal surgery or trauma?** ☐ **Yes** ☐ **No** _____

Are you currently experiencing or have you ever been diagnosed with any of the following:

Shortness of Breath ☐ **Yes** ☐ **No If yes, how long?** _____

Fatigue ☐ **Yes** ☐ **No If yes, how long?** _____

Difficulty Breathing ☐ **Yes** ☐ **No If yes, how long?** _____

Birth Trauma ☐ **Yes** ☐ **No If yes, when?** _____

Cancer ☐ **Yes** ☐ **No If yes, please explain:** _____

Spinal Cord Disorder ☐ **Yes** ☐ **No If yes, please describe:** _____

Injury (Ex: neck/chest/abdomen) ☐ **Yes** ☐ **No If yes, when did injury occur?** _____ **Injury details:**

_____

Neurological Disorder (Ex: Stroke, MS) ☐ **Yes** ☐ **No If yes, please specify:** _____

Date of diagnosis: _____

Muscular Disorder (Ex: Muscular Dystophy) ☐ **Yes** ☐ **No If yes, Please specify:** _____

Date of diagnosis: _____

Other important medical conditions: _____

_____

Current Medications:

I agree that the above information is correct *(Do not fill out until after technologist has reviewed):*

Patient Signature: _____ Todays Date: _____