SDMI STEINBERG DIAGNOSTIC

INTAKE QUESTIONNAIRE XRAY

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)*:

Pre-operation exam ☐ **Yes** ☐ **No**

Additional Tech Notes:

Previous Imaging Studies Related to Todays Exam	**Date**
Previous Surgeries Related to Todays Exam	**Date**

Is your area of concern related to an injury? ☐ **Yes** ☐ **No** **If yes, continue below:**

Date of Injury _____ **How were you injured?** ☐ **Car Accident** ☐ **Work** ☐ **Other**

Describe Injury *(please be specific)* _____

Are you experiencing pain? ☐ **Yes** ☐ **No** **(if yes, continue below)**

Where? _____ **How long?** _____

Describe your pain: ☐ **Sharp** ☐ **Dull** ☐ **Other (please describe):** _____

Are you a Smoker? ☐ **Current** ☐ **Past** ☐ **Never** **Current or past, do/did you smoke cigarettes** ☐ **Yes** ☐ **Other**

If other, please specify: _____ **How many years?** _____

Have you ever been diagnosed with Cancer? ☐ **Yes** ☐ **No** **(if yes, continue below)**

What type of Cancer? _____ **Location:** _____ **Date Diagnosed:** _____

Current status: ☐ **Recurrence** ☐ **Remission** ☐ **Newly Diagnosed**

Treatment: ☐ **Surgery** ☐ **Radiation** ☐ **Chemo** ☐ **Other Cancer Treatment(s):** _____

Has it spread? ☐ **Yes** ☐ **No** **If yes, Where:** _____

Is your visit today related to this Cancer diagnosis? ☐ **Yes** ☐ **No**

Other important medical conditions (please describe): _____

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

Patient Signature: _____ Todays Date: _____