SDMI STEINBERG DIAGNOSTIC

INTAKE QUESTIONNAIRE
CT ADVANCED BODY IMAGING

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)*:

IV Access:

Contrast: _____ml from _____ml bottle

Concentration: _____ mg/mol

☐ **Guerbet Optiray** ☐ **GE Omnipaque**

Additional 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:**

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

Describe Injury *(please be specific)* _____

Have you ever been diagnosed with Diabetes? ☐ **Yes** ☐ **No** **If yes, medication?** ☐ **Oral** ☐ **Injection** _____

Have you ever had Renal Failure? ☐ **Yes** ☐ **No** **If yes, when?** _____

Have you had kidney surgery or do you have only one kidney? ☐ **Yes** ☐ **No** **If yes, which kidney?** ☐ **Right** ☐ **Left**

Have you ever been diagnosed with Cancer? ☐ **Yes** ☐ **No** **If yes, what type?** _____

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

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

Date of Last Treatment: _____ **Current status:** ☐ **Newly Diagnosed** ☐ **Remission** ☐ **Recurrence**

Have you had your Gallbladder removed? ☐ **Yes** ☐ **No** **When?** _____

Have you had any Hernia repairs? ☐ **Yes** ☐ **No** **Location?** _____ **When?** _____

Have you ever had any Stents placed in your body? ☐ **Yes** ☐ **No** **Location?** _____ **When?** _____

Have you ever tested positive for COVID-19? ☐ **Yes** ☐ **No** **When?** _____

Are you a Smoker? ☐ **Current** ☐ **Past** ☐ **Never**

If Current or Past, Did/Do you smoke cigarettes? ☐ **Yes** ☐ **other:** _____ **How many years?** _____

For Women Only: **Have you had a Hysterectomy?** ☐ **Yes** ☐ **No** **Ovaries Removed?** ☐ **Right** ☐ **Left** ☐ **Both**

Lumps or Bumps you can feel? ☐ **Yes** ☐ **No** **Where?** _____

Pain or Difficulty Swallowing? ☐ **Yes** ☐ **No** **How Long?** _____

Shortness of Breath or Difficulty Breathing? ☐ **Yes** ☐ **No** **How Long?** _____

Chest Pain or Chest Pressure? ☐ **Yes** ☐ **No** **How Long?** _____

History of Blood Clot in Lungs? ☐ **Yes** ☐ **No** **When?** _____

Diagnosed with COPD/Emphysema? ☐ **Yes** ☐ **No** **When?** _____

Nausea, Vomiting or Diarrhea? ☐ **Yes** ☐ **No** **How Long?** _____

Constipation or Bloating? ☐ **Yes** ☐ **No** **How Long?** _____

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

Patient Signature: _____ Todays Date: _____