SDMI STEINBERG DIAGNOSTIC

INTAKE QUESTIONNAIRE
CT MUSCULOSKELETAL 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

Are you currently experiencing any of the following?			**Where?** *Example: Shoulder*	**How Long?** *Example: 2 years*
Joint Pain	**☐ Yes ☐ No**	**☐ Right ☐ Left ☐ Both**		
Arthritis	**☐ Yes ☐ No**	**☐ Right ☐ Left ☐ Both**		
Weakness	**☐ Yes ☐ No**	**☐ Right ☐ Left ☐ Both**		
Mass	**☐ Yes ☐ No**	**☐ Right ☐ Left ☐ Both**		
Infection	**☐ Yes ☐ No**	**☐ Right ☐ Left ☐ Both**		
Loss of Range of Motion	**☐ Yes ☐ No**	**☐ Right ☐ Left ☐ Both**		
Other:	**☐ Yes ☐ No**	**☐ Right ☐ Left ☐ Both**		

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

Patient Signature: _____ Todays Date: _____