SDMI STEINBERG DIAGNOSTIC

INTAKE QUESTIONNAIRE
CT CARDIAC 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):*

Previous Imaging Studies Related to Todays Exam	Date

Previous Surgeries Related to Todays Exam	Date

TECH NOTES *(for internal use only)*:

IV Access:

Contrast: _____ml from _____ml bottle

Concentration: _____ mg/mol

☐ Guerbet Optiray ☐ GE Omnipaque

Additional Notes:

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

Do you currently have or have you ever had any of the following conditions or procedures?

High Blood Pressure/Hypertension ☐ Yes ☐ No If yes, How Long? _____

High Cholesterol ☐ Yes ☐ No If yes, How Long? _____

Shortness of Breath ☐ Yes ☐ No If yes, How Long? _____

Any Chest Pain ☐ Yes ☐ No If yes, How Long? _____

Stress Test ☐ Yes ☐ No If yes, Were Results Normal? ☐ Yes ☐ No

Abnormal EKG ☐ Yes ☐ No If yes, When? _____

Heart Bypass Surgery ☐ Yes ☐ No If yes, How Many? _____ When? _____

Stents placed in your heart ☐ Yes ☐ No If yes, How Many? _____ When? _____

Family history of Heart Disease ☐ Yes ☐ No If yes, Which Family Member(s)? _____

Taken any sexual performance drugs in the last 48 hours? ☐ Yes ☐ No If yes, When? _____

Are you a Smoker? ☐ Current ☐ Past ☐ Never Current or Past, Did/Do you smoke Cigarettes?

☐ Yes ☐ Other: _____ How Many years? _____

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

Patient Signature: _____ Todays Date: _____