SDMI STEINBERG DIAGNOSTIC

INTAKE QUESTIONNAIRE
MRI 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)*:

Sedation:	
MRI Safety:	

Guerbet Dotarem Contrast:

_____ from _____ **vial**

Additional Notes:

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)*

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

What type of cancer? _____ **Location:** _____

Date diagnosed: _____ **Current status:** ☐ **Newly Diagnosed** ☐ **Remission** ☐ **Recurrence**

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

Date of Last Treatment: _____ **Has it spread?** ☐ **Yes** ☐ **No** **If yes, where?** _____

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

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?** _____

Diabetes ☐ **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: _____