

EASTSIDE DIAGNOSTIC IMAGING, PLLC**DIAGNOSTIC PROCEDURE QUESTIONNAIRE**

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE

PATIENT NAME: _____

DOB: _____

AGE: _____

Account Number: _____

SOCIAL SECURITY #: _____

FEMALE / MALE (PLEASE CIRCLE)

REFERRING PHYSICIAN/PHONE NUMBER: _____

IF YOU ARE PREGNANT, PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY.

ARE YOU OR COULD YOU BE PREGNANT? YES NO _____(INITIAL) DATE OF LAST MENSTRUAL CYCLE: ___/___/_____

ARE YOU CURRENTLY BREAST FEEDING? YES NO _____(INITIAL)

HAVE YOU HAD ANYTHING TO EAT IN THE LAST 3 HOURS? YES NO IF YES, WHAT TIME? _____

WHAT SYMPTOMS OR COMPLAINTS BROUGHT YOU HERE? _____

PLEASE SPECIFY THE LOCATION AND DURATION OF SYMPTOMS: _____

WHICH SIDE? RIGHT LEFT OTHER _____

DO YOU HAVE ANY ALLERGIES? YES NO IF YES, EXPLAIN _____**HAVE YOU HAD A CONTRAST DYE INJECTION BEFORE?** YES NO

IF YES, DID YOU HAVE ANY PROBLEMS OR REACTION TO THIS INJECTION? YES NO

IF YES, PLEASE EXPLAIN _____

HAVE YOU BEEN MEDICATED FOR THIS PROCEDURE? YES NO TECH INITIALS _____

PLEASE LIST ALL PRIOR SURGERIES:

<input type="checkbox"/>	NONE	DATE
<input type="checkbox"/>	_____	___/___/_____
<input type="checkbox"/>	_____	___/___/_____
<input type="checkbox"/>	_____	___/___/_____

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER OR SERIOUS ILLNESS? YES NO

IF YES, WHAT KIND? _____

IF YES, HAVE YOU HAD CHEMOTHERAPY? YES NO DATES: ___/___/_____

IF YES, HAVE YOU HAD RADIATION THERAPY? YES NO DATES: ___/___/_____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?**DO YOU HAVE ASTHMA?** YES NO **IF YES, ARE YOU CURRENTLY SYMPTOMATIC?** YES NO

HIGH BLOOD PRESSURE? YES NO LUNG DISEASE? YES NO

SHORTNESS OF BREATH? YES NO HEART DISEASE? YES NO

KIDNEY DYSFUNCTION? YES NO

ARE YOU CURRENTLY ON DIALYSIS? YES NO IF YES, DATE OF NEXT SESSION ___/___/_____

ARE YOU OR HAVE YOU EVER BEEN A SMOKER? YES NO

IF YES, HOW MANY PACKS PER DAY? _____
FOR HOW MANY YEARS? _____

ARE YOU A DIABETIC? YES NO IF YES, ARE YOU TAKING:

GLUCOPHAGE METFORMIN OR GLUCOVANCE
(PLEASE CIRCLE AND INITIAL)

I ATTEST THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT OR GUARDIAN OR PERSON AUTHORIZED TO CONSENT FOR PATIENT _____

AS PART OF THIS PROCEDURE I CONSENT TO HAVE INTRAVENOUS CONTRAST MATERIAL GIVEN TO ME. THIS INTRAVENOUS CONTRAST MATERIAL IS ADMINISTERED THROUGH A NEEDLE PLACED IN THE VEIN. THE INDICATIONS AND RISKS OF THIS PROCEDURE HAVE BEEN EXPLAINED TO ME. IT HAS ALSO BEEN EXPLAINED TO ME THAT THE POTENTIAL REACTIONS TO THE CONTRAST, WHILE RARE CAN INCLUDE ALLERGIC REACTION FROM MILD TO SEVERE SWELLING OR INFECTION OF THE INJECTION SITE, BLEEDING, DIFFICULTY BREATHING, LOW BLOOD PRESSURE AND KIDNEY DYSFUNCTION.

THERE ARE TWO TYPES OF CONTRAST AVAILABLE FOR USE FOR THIS TYPE OF EXAM: FOR THE SAFETY OF OUR PATIENTS WE USE ONLY THE NON-IONIC CONTRAST AGENT, WHICH IS LESS LIKELY TO PRODUCE REACTIONS.

SIGNATURE OF PATIENT OR GUARDIAN OR PERSON AUTHORIZED TO CONSENT FOR PATIENT _____

TECHNOLOGIST NOTES:

TECH SIGNATURE