RADIOLOGY SERVICES OF NEW YORK, P.C.

Patient Name:	DOB:
Address:	·
Home #: Cell #:	Social Security #:
Referring Physician:	
Please explain your symptoms (the nature of	your problem):
When and how did your problem develop? _	or and tion aid your mobilest develop
Did you ever have surgery on the area being s	
If "Yes," what type of surgery?	When was the surgery?
Do you or have you ever had cancer? Yes	☐ No If "Yes," what type?
	The same out boy evan thanby evan we
Do you have any of the following: Diabe	
List any medical illnesses you have	
Female Patients Only:	
When was your last menstrual period	Are you Pregnant? Yes No
Any abnormal vaginal bleeding?	We are was your last nonstrust editor.
Chest:	'amount langua terroreti vist.
Do you or did you ever smoke? Yes No	If "Yes" How much and for how long?
Do you have any of the following: Cough	Shortness of breath Phlegm Chest pain
Do you have or ever suffered from: Heart pro	blems Pneumonia Asthma
Emphyse	ma Exposure to asbestos Trauma
Abdomen and or Pelvis:	Hard, North, Sofian Carollel
If you have pain in your abdomen, specify location	n: Right Upper Right Lower Left Upper Left Lower
If you have pain in your flank (side area), specify	location: Right Left Both
If you have pain in your pelvic area, specify locati	ion: Right Left Both
Please mark any of the following as may apply to	you:
Nausea Vomiting Diarrhea	Blood in stool Blood in urine Constipation
Any recent endoscopy or colonoscopy? F	Findings
Signature	Date

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Referring Physician:			celengy Physicia
Please explain your symptoms	the nature of your problem		st ense explain yeu
When and how did your probl	em develop?	your problem levelop?	bio worl one nos?
Did you ever have surgery on			
If "Yes," what type of surgery	?	When was the surg	gery?
Do you or have you ever had	metalen ac VIIII DE T	VITTO CONTRACTOR	-
What treatment have you had	and when?		
Do you have any of the	e following: Diabe	etes Asthma	Allergies
List any medical illnesses you	have		
Female Patients Only:			* - 17 - E
When was your last menstrual		Are you Pregnant	7 TVes TNo
Any abnormal vaginal bleed			
Bone, Joint, Muscle:	to brus dos		
Please check any of the follow	ing that apply:		E .
Recent trauma (fall, car accid		welling Clicking N	lumbness/tingling
Do you have arthritis: Yes	No 07/5	Emple sera	
Head, Neck, Spine, Carotid			
Did you have an injury to you	r head?	yes, describe	
Do you have a known neurolo	gical condition?	yes, what?	•
Do you have any of the follow	ving?: (If yes, how long?)_	ieu. Aankeeide wear, specify k	rit diaqlo illi le
Headaches	☐ Seizures	Sinus co	ngestion
Dizziness	Nausea	Imbalan	ce via hara we
Hearing loss (R or L)	☐ Vision problems	(R or L) Difficult	y walking
☐ Numbness/tingling			obate i i me ava ava
Signature		Date	