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? _____

Did you ever have surgery on the area being scanned today? ☐ Yes ☐ No

If "Yes," what type of surgery? _____ When was the surgery? _____

Do you or have you ever had cancer? ☐ Yes ☐ No If "Yes," what type?_____

What treatment have you had and when? _____

Do you have any of the following: ☐ Diabetes ☐ Asthma ☐ Allergies

List any medical illnesses you have _____

Female Patients Only:

When was your last menstrual period _____ Are you Pregnant? ☐ Yes ☐ No

Any abnormal vaginal bleeding?_____

Chest:

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 problems ☐ Pneumonia ☐ Asthma
☐ Emphysema ☐ Exposure to asbestos ☐ Trauma

Abdomen and or Pelvis:

If you have pain in your abdomen, specify location: ☐ 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 location: ☐ 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? Findings _____

Signature_____ Date_____

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Bone, Joint, Muscle:

Please check any of the following that apply:

☐ Recent trauma *(fall, car accident, etc.)* ☐ Stiffness ☐ Swelling ☐ Clicking ☐ Numbness/tingling

Do you have arthritis: ☐ Yes ☐ No

Head, Neck, Spine, Carotid

Did you have an injury to your head? If yes, describe _____

Do you have a known neurological condition? If yes, what? _____

Do you have any of the following?: (If yes, how long?)_____

☐ Headaches	☐ Seizures	☐ Sinus congestion
☐ Dizziness	☐ Nausea	☐ Imbalance
☐ Hearing loss (R or L)	☐ Vision problems (R or L)	☐ Difficulty walking
☐ Numbness/tingling		

Signature_____ Date_____