Advanced Imaging Associates
Diagnostic Imaging History Sheets

Patient's Name ___________________________________

Height: _______ Weight: _______ Age: _____ Sex: _____

Females Only: LMP ______, is there any chance that you could be pregnant? YES NO

Has this exam been explained to you? YES NO

Have you ever had a server allergic reaction to anything? YES NO

To what?	What kind of reaction?
______________________	________________________
______________________	________________________

Are you allergic to any medications? YES NO

Name of medications:	Type of reaction?
______________________	_______________________
______________________	_______________________

Do you have a history of asthma? YES NO
When was your last asthma attack? __________________
Name of current medication currently being taken for asthma:
____

Do you have a history of hay fever? YES NO
Name of medications currently being taken for hay fever: _______
____

Do you have a history of heart disease?	YES	NO
Do you have high blood pressure?	YES	NO
Have you ever had kidney problems?	YES	NO
Are you diabetic?	YES	NO
Do you take insulin?	YES	NO
do you take Glucophage?	YES	NO

Have you ever had intravenous contrast before? YES NO
Did you experience any reaction? YES NO
If yes, describe reaction: ___________________________
____

Do you have a history of epilepsy or seizures? YES NO
When was your last seizure? ________________________

Do you take any medications on a daily basis? YES NO
Name of medications: _____________________________
____

Have you ever been stung by a bee or other stinging insect? YES NO
Did you require medication and/or emergency care for the sting? YES NO
Name of medications and/or description of emergency care: _______
____

List previous surgeries: ____________________________________
____

Have you had lab work done recently: YES NO
Were the results made available to you YES NO
Lab results: ____

Have you ever smoked cigarettes? YES NO
If yes, please give details of your smoking history: (number of packs, when did you quite, etc.) ___________________________
____

Briefly describe the reason you went to see your doctor:
____
____

Patient's Signature: _______________________ Date: __________

Reviewed By: ____