Revised 11/21/16

Medical History Questionnaire

university medical imaging
UMI
Where the experience is better.

Name: ______________________________________ Date of Birth: ________________________

Sex assigned at birth: ☐Male ☐Female Height: ________ Weight: ________

What Complaint(s), Symptom(s), and/or change(s) in your treatment caused you to seek medical help?

Did you have an injury? ☐Y ☐N | Date of Injury:

The injury is: *☐Workman's Compensation* *☐Related to a Motor Vehicle Crash* *☐Neither*

What Happened?

Have you ever had an imaging study that required the injection of **intravenous contrast**?	☐Y ☐N	Food, Medicine, and/or other **Allergies** and type of reaction(s):
Have you ever had an **adverse reaction to contrast?**	☐Y ☐N	
If Yes, explain:		

List all prior imaging exams (CT, Nuclear Medicine, MRI, PET, Ultrasound, X-Ray, etc.):

Type of Exam	*Done Where*	*Date*

Do YOU have a history of any of the following (check all that apply)? ☐ **NONE OF THE BELOW**

☐**Cancer**, type(s): ______________________________	☐Diabetes (Medications: ___________________________)
Have you had Radiation Therapy? ☐Y ☐N	☐High Blood Pressure (Do you take medication? ☐Y ☐N)
Have you had Chemotherapy? ☐Y ☐N	☐History of Kidney Transplant or Kidney Surgery (circle one)
☐Heart Disease, explain ________________________	☐History of Kidney Cancer
☐Immune Suppressed	☐Have only ONE Kidney
☐Thyroid Problems, explain ______________________	☐On Dialysis, Date of next appointment ____________
☐Emphysema/COPD	☐Asthma

Tobacco use ***(check all that apply)*****:** ☐Never ☐Smoking (_____ packs per day) ☐Chewing ☐Quit (________ years ago)

Other Medical Problems:	**Current Medications:**	**List ALL Prior Surgeries**

Possibility of Pregnancy? ☐Y ☐N Are you using birth control? ☐Y ☐N Are you breastfeeding? ☐Y ☐N

**I have been advised of the possibility of adverse effects of X-rays during pregnancy. I do not believe that I am pregnant, but if necessary, I will seek the advice of my private doctor.*

Date of last menstrual period:

By signing below, I understand that I have the right to refuse all or any imaging services. I have the right to stop any imaging exam at any time.

Signature: ______________________________________ Date: ____________________

Nursing Notes

Gauge:_____	BUN:_____
Site:_______	Creat:_____
RN:_______	GFR:_____
RN:_______	Date:_____

C-003A