The following questionnaire will facilitate the scheduling of any additional testing your doctor may request

Name___________________________ DOB_______________________________________

Contact Number:________________________Other__________________________

Primary Insurance____________________________Circle: PPO HMO SENIOR OTHER

Secondary Insurance: _________________________ Circle: PPO HMO SENIOR OTHER

Where would you like exams (e.g. CAT scan) to be scheduled?

____

Please Circle All Applicable

Available Days:	Mon Tues	Wed Thurs	Fri Sat	All		
Available Times:	Morning	Afternoon	Early Evening	Any		
Allergic to:	Iodine	Shrimp	Lobster	Shellfish	None	
Are you Diabetic:	Yes	No				

If so, what medication(s)?____

Are you taking blood thinners (e.g. Coumadin, Warafarin, Aspirin) Yes No

If so, what medication(s)?____

List any implants:_______________________ Date placed:___________________________

List any metal in body: __________________Date placed: ___________________________

Do you have a pacemaker?	Yes	No
Do you have both kidneys?	Yes	No
History of renal failure?	Yes	No
Do you have asthma?	Yes	No
Do you have hypertension?	Yes	No

List any breast problems: ____

Are you claustrophobic	Yes	No
Are you or could you be pregnant?	Yes	No
Are you TB positive	Yes	No

List any operations:____

Patient Signature_____________________________ DOB:___________________________

Have you previously had scans done? Yes No

If so, please indicate the facility____

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