DT0002

BAYLOR RADIOLOGISTS
a radiology partners affiliated practice

PATIENT INFORMATION
DEPARTMENT OF RADIOLOGY

Addressograph or Print Patient Name and Account Number

Patient's Name: _____ Date: _____ Time: _____

Height: _____ ft. _____ inches **Weight:** _____ lbs/kg. **Last time you ate or drank:** _____ am / pm

Have you ever had a CT Scan, IVP/Kidney study, Angiogram or MRI procedure before? ☐ **Yes** ☐ **No**

If so, did you receive contrast? ☐ **Yes** ☐ **No** How did it make you feel? _____

Did you bring any x-ray films/pictures with you today for review and/or comparison? ☐ **Yes** ☐ **No**

Facility where previous imaging studies were performed: _____ Date performed: _____

Are you pregnant? ☐ **Yes** ☐ **No** Are you lactating? ☐ **Yes** ☐ **No** Date of last menstrual period: _____

Did you bring any lab/blood test results with you today? ☐ **Yes** ☐ **No**

For patients undergoing Cardiac Stress Testing: Have you had any caffeinated/decaffeinated products within the past 12 hours (i.e. soda, diet soda, chocolate, strawberries, tea)? ☐ **Yes** ☐ **No**

List any known medication or food allergies:

☐ No known drug allergies ☐ No known allergy to iodine (i.e. IVP / Kidney study, Angiogram, CT dye)

☐ No known allergy to MRI dye ☐ Penicillin ☐ Latex ☐ Sensitivity to tape ☐ No known food allergies

☐ **Yes, I have allergies:** ***please list and describe reaction in the space provided below:***

☐ **I DO NOT TAKE ANY MEDICATIONS**

Name of Medication (Include non-prescription medication, herbal supplements)	Reason for Use:	Dose/ Strength	How often taken	Date and time of last dose:	***Staff use only Reviewed on Admission***

PAIN:

Do you have any pain? ☐ Yes ☐ No If yes, where is your pain located? _____

Please describe your pain: _____

*Rate your pain on scale of 0-10 (0 no pain) Pain you have now (0-10) _____ Usual pain (0-10) _____

Comfort Goal: _____ Is your pain control satisfactory? ☐ Yes ☐ No If no, please explain: _____

Medical History: ☐ None

☐ Asthma/Lung problems ☐ Blood/Coagulation problems ☐ Cancer (describe) _____

☐ Congestive Heart Failure ☐ Coronary Artery Disease ☐ Chest Pain ☐ Diabetes ☐ Kidney failure ☐ Dialysis * if yes, what days do you dialyze? M Tu We Tr Fr Sa Date of your last dialysis? _____ ☐ Heart Attack ☐ High Blood Pressure

☐ Hysterectomy ☐ Seizures ☐ Sickle Cell ☐ Stroke ☐ TB ☐ Tobacco use: *describe: _____

☐ Alcohol Use *describe: _____ Other: _____

Surgeries and Invasive Procedures: ☐ I ***have not*** had any surgery or procedure ☐ Yes, I have had surgery and/or procedures, please list procedure and date _____

Other: Is there any additional information we should know that was not specifically asked elsewhere on the database?

Completed by: _____ Relationship to patient: _____ Phone # of driver: _____
(Please Print)

Reviewed by: _____ RN / Technologist Date: _____ Time: _____