OPTIMA DIAGNOSTIC IMAGING

CT • MRI • PET/CT • BONE SCAN

ADVANCED TECHNOLOGY. UNSURPASSED CONVENIENCE.

IMAGING QUESTIONNAIRE

Date: _____

Name: _____ D.O.B:_____HT: _____ WT: _____Sex:_____

Ref. Physician: _____Next appointment with doctor:_____

Allergies: _____Iodine/Shellfish_____

Medical History (please mark all that apply):

☐ Cardiac Pacemaker	☐ IUD	☐ Seizure Disorder
☐ Brain aneurysm clips	☐ Heart Disease	☐ Shortness of Breath
☐ Aortic Clips	☐ High Blood Pressure	☐ Artificial heart valve
☐ Electrodes	☐ Implanted Device	☐ Stroke
☐ Cancer	☐ Thyroid Disorder	☐ Joint replacement
☐ Cochlear implants	☐ Kidney/Liver Disease	☐ Family History of Anesthesia Problems
☐ Asthma	☐ Internal Catheter	☐ Family History of Kidney Disease
☐ Dentures	☐ Insulin Pump	☐ Metal Mesh
☐ Arthritis	☐ Neurological Disorder	☐ Chemotherapy
☐ Dialysis	☐ Metal slivers in the eye	☐ Hearing aids
☐ Radiation Therapy	☐ Colostomy/Ileostomy	☐ Drains/Open Wounds

☐ Other/ Location (please list)_____

Additional Patient Information:

Claustrophobic? (Yes / No) Do you have any metal in your body (Plates, Screws, Pins, clips etc..) ? (Yes / No)

Hx Of Cancer? (Yes/No) Pregnant (Yes/No) Pacemaker (Yes/No)

Are you diabetic? (Yes/No) if Yes, and taking Metformin, it must be discontinue for 48 hours.

Have you had anything to eat today? (Yes/No) When:_____

Medications (Dose)?_____

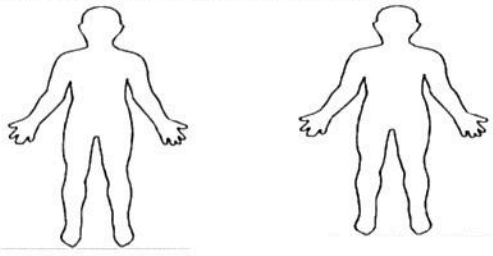
Previous surgeries/studies to the **body part** we are scanning? (Yes / No) If yes,explain_____

_____

Briefly describe your symptoms in relation to today's Scan: _____

_____

Please mark (X) where the pain is located:



(front) (back)

Does this pain go down your:		
Arm	Right	Left
Leg	Right	Left
Other _____	Right	Left

Signature: _____

(PLEASE REMOVE ALL JEWELRY !)