SDMI STEINBERG DIAGNOSTIC

Intake Questionnaire
ADVANCED IMAGING

Please answer all questions below and notify the technologist of any metal inside or on your body. For MRI's, please remove all removable metal from your body such as hearing aides, hairpins, jewelry, dentures, partial plates, etc. SDMI IS NOT RESPONSIBLE FOR HEARING AIDS BROUGHT INTO THE EXAM ROOM.

Patient Information

Patient Number _____ *to be filled in by tech*

First Name _____ Last Name _____ Age _____

DO YOU HAVE? (circle yes or no for all)

Pacemaker / Wires / Cardiac Defibrillator?	YES	NO	Brand: _____
Brain Aneurysm Clips / Coils?	YES	NO	
Neurostimulator / Wires?	YES	NO	Where: _____
Bone Stimulator / Wires?	YES	NO	Where: _____
Cochlear Implant / Ear Implant?	YES	NO	
Breast Tissue Expander?	YES	NO	
Metallic Foreign Body in Eye?	YES	NO	

If you circled yes to ANY of the above you must verbally NOTIFY the tech before your exam.

Metal in the body (joints, rods, screws, clips)?	YES	NO	Where:
Stents or Filters?	YES	NO	Where: _____
Shunt Valves Programmable?	YES	NO	_____
Shunt Valves Non-Programmable?	YES	NO	
Surgically Implanted Device?	YES	NO	Where:
Medication Patch?	YES	NO	_____
Hearing Aid	YES	NO	If Yes, you must leave outside of room
Tattoos or Pemanent Makeup	YES	NO	Where: _____
Any clothing containing Metal	YES	NO	If Yes/Unsure you will need to change into a gown
Recent Barium Enema/UGI	YES	NO	
IV Dye (MRI or CT) in last 48 hours	YES	NO	

History *(circle yes or no for all)*

Are you pregnant / breastfeeding?	YES	NO
Have you ever had Renal Failure / Dialysis?	YES	NO
If Yes, when: _____		
Do you have High Blood Pressure?	YES	NO
Do you have Diabetes?	YES	NO
If Yes: *(circle one)* Insulin Oral Medication		
COPD	YES	NO
Cardiac Disease	YES	NO

History Continued *(circle all that apply)*

Are you a smoker? Current Past Never

If yes, how many years? _____

Allergies *(list all, medications)*

_____

_____

_____

Patient Signature: _____ **Todays Date:** _____

TECH NOTES: *(for internal use only)*

Notes _____

_____

_____

SDMI STEINBERG DIAGNOSTIC

History Questionnaire
Advanced Spine Imaging

Patient Information Patient Number _____ *to be filled in by tech*

First Name _____ Last Name _____ Age _____

Reason for your Exam (*please describe in detail*)

_____

_____

_____

TECH NOTES: *(for internal use only)*

Contrast _____

Sedation _____

Notes _____

SYMPTOMS, Body *(circle all that apply)*

Neck Pain	Acute	Chronic	Due to Trauma
Mid Back Pain	Acute	Chronic	Due to Trauma
Low Back Pain	Acute	Chronic	Due to Trauma
Face Numbness	Right	Left	Bilateral
Face Weakness	Right	Left	Bilateral
Body Numbness	Right	Left	Bilateral
Body Pain	Right	Left	Bilateral

How long have you had the above symptoms:

_____

_____

_____

SYMPTOMS, Extremeties *(circle all that apply)*

Radiculopathy

Arm Numbness	Right	Left	Bilateral
Arm Pain	Right	Left	Bilateral
Leg Numbness	Right	Left	Bilateral
Leg Pain	Right	Left	Bilateral

Myelopathy

Arm Weakness	Right	Left	Bilateral
Leg Weakness	Right	Left	Bilateral

Limited Range of Motion? NO ___ YES ___

If YES, list exact location: _____

Is your problem related to an injury? NO _____ YES _____ *(if yes continue)*

Date of Injury _____ How were you injured *(circle one)* Car Accident Work Other

Describe Injury *(please be specific)* _____

_____

Have you ever been diagnosed with cancer? NO _____ YES _____ *(if yes continue)*

What type of cancer _____ Location _____ Date Diagnosed _____

Current Status *(please circle one)* Newly Diagnosed Recurrence Remission

Treatment *(please circle all that apply)* Surgery Radiation ChemoTherapy

Date of last Treatment _____

Has it spread? NO _____ YES _____ If Yes, Where _____

Is your visit today related to this cancer diagnosis NO _____ YES _____

Previous surgeries or imaging studies related to the affected area you are being seen for today.
(please list specifically, what and when)

Procedure Description	Date
_____	_____
_____	_____
_____	_____
_____	_____

SDMI STEINBERG DIAGNOSTIC

History Questionnaire
Advanced Head Imaging

Patient Information Patient Number _____ *to be filled in by tech*

First Name _____ Last Name _____ Age _____

Reason for your Exam (*please describe in detail*)

_____

_____

_____

TECH NOTES: *(for internal use only)*

Contrast _____

Sedation _____

Notes _____

Head *(Circle all that Apply)*

Stroke Memory Loss Tremor Dizziness
Seizures MS Hemorrhage

Headaches *(circle one)*
Acute Chronic Severe Due to Trauma

Migraines *(circle one)* Acute Chronic

Vision Loss *(circle one)* Right Left Both

Hearing Loss *(circle one)* Right Left Both

Numbness/Tingling Where _____

History of head trauma? YES NO

Sinus *(circle all that apply)*

Sinus Infections	Headaches	Facial Pain
Congestion	Runny Nose	Frequent Colds
Sore Throats	Toothaches	Chronic Cough
Post Nasal Drip	Nose Bleeds	Deviated Nasal Septum
Nasal Polyps	Snoring	Sleep Apnea

Previous Nasal Fracture

Please list any other related symptoms

_____

_____

Previous sinus surgery? YES NO

If yes, procedure description and date:

_____

_____

Is your problem related to an injury? NO _____ YES _____ *(if yes continue)*

Date of Injury _____ How were you injured *(circle one)* Car Accident Work Other

Describe Injury *(please be specific)* _____

_____

Have you ever been diagnosed with cancer? NO _____ YES _____ *(if yes continue)*

What type of cancer _____ Location _____ Date Diagnosed _____

Current Status *(please circle one)* Newly Diagnosed Recurrence Remission

Treatment *(please circle all that apply)* Surgery Radiation ChemoTherapy

Date of last Treatment _____

Has it spread? NO _____ YES _____ If Yes, Where _____

Is your visit today related to this cancer diagnosis NO _____ YES _____

Previous surgeries or imaging studies related to the affected area you are being seen for today.
(please list specifically, what and when)

Procedure Description	Date
_____	_____
_____	_____
_____	_____
_____	_____

SDMI STEINBERG DIAGNOSTIC

History Questionnaire
Advanced Oncologic and Body Imaging

Patient Information Patient Number _____ *to be filled in by tech*

First Name _____ Last Name _____ Age _____

Reason for your Exam (*please describe in detail)*

_____

_____

_____

TECH NOTES: *(for internal use only)*

Contrast _____

Sedation _____

Glucose (PET) _____

SYMPTOMS *(circle all that apply)*

Pain	Acute	Chronic
Mass	Acute	Chronic
Infection	Acute	Chronic

What is the exact location of your symptoms:

_____

COPD Cardiac Hepatitis

SYMPTOMS, Continued *(circle all that apply)*

Are you a smoker? Current Past Never

If yes, how many years? _____

WOMEN ONLY, please continue *(circle all that apply)*

Had a hysterectomy (uterus removed) YES NO

Had ovaries removed? Right Left Both

Any Cancer Diagnosis and History: Date Diagnosed _____

What type of cancer do you have? _____

Location _____

Current Status: Newly Diagnosed, When? _____

Recurrence, When? _____

Remission, How Long? _____

Treatment: Surgery Date of Last Treatment? _____

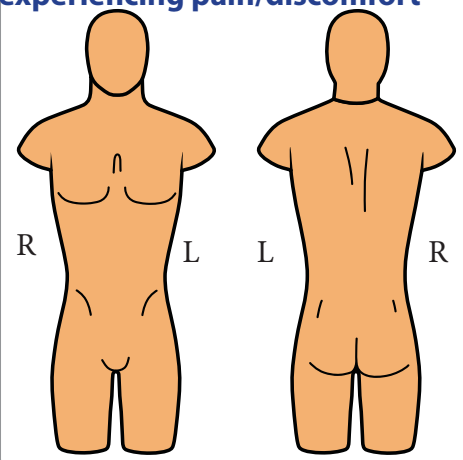
Radiation Date of Last Treatment? _____

ChemoTherapy Date of Last Treatment? _____

Has it spread? NO YES If Yes, Where _____

Is your visit today related to this cancer diagnosis NO _____ YES _____

Please mark where you are experiencing pain/discomfort



Related Studies: Have you had a previous MRI, CT, or related Studies? ___ NO ___YES *(if yes continue below)*

Date of Study: _____ Type of Study: _____

Date of Study: _____ Type of Study: _____

Date of Study: _____ Type of Study: _____

Previous surgeries, recent hospitalization, imaging studies and other important medical conditions
(please list specifically, what and when)

Procedure Description	Date

SDMI STEINBERG DIAGNOSTIC

History Questionnaire
Advanced Musculoskeletal Imaging

Patient Information Patient Number _____ *to be filled in by tech*

First Name _____ Last Name _____ Age _____

Reason for your Exam (*please describe in detail*)

_____

_____

_____

TECH NOTES: *(for internal use only)*

Contrast _____

Sedation _____

Notes _____

SYMPTOMS, Extremeties *(circle all that apply)*

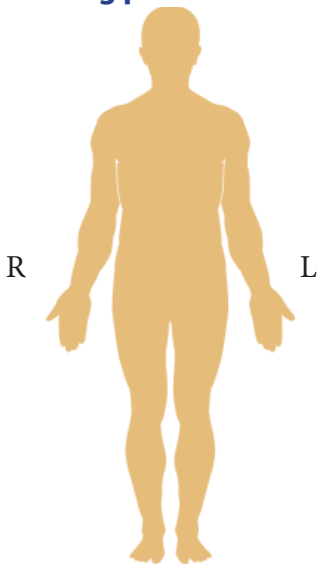
Previous Joint Injections	YES	NO	Where _____	
Joint Pain	Acute	Chronic	Right	Left
Arthritis	Acute	Chronic	Right	Left
Stiffness	Acute	Chronic	Right	Left
Weakness	Acute	Chronic	Right	Left
Loss of Range of Motion	Acute	Chronic	Right	Left
Mass	Acute	Chronic	Right	Left
Infection	Acute	Chronic	Right	Left

What is the exact location of your symptoms:

_____

_____

Please mark where you are experiencing pain/discomfort



Is your problem related to an injury? NO _____ YES _____ (*if yes continue*)

Date of Injury _____ How were you injured *(circle one)* Car Accident Work Other

Describe Injury *(please be specific)* _____

_____

Have you ever been diagnosed with cancer? NO _____ YES _____ (*if yes continue*)

What type of cancer _____ Location _____ Date Diagnosed _____

Current Status *(please circle one)* Newly Diagnosed Recurrence Remission

Treatment *(please circle all that apply)* Surgery Radiation ChemoTherapy

Date of last Treatment _____

Has it spread? NO _____ YES _____ If Yes, Where _____

Is your visit today related to this cancer diagnosis NO _____ YES _____

Previous surgeries or imaging studies related to the affected area you are being seen for today.
(please list specifically, what and when)

Procedure Description	Date
_____	_____
_____	_____
_____	_____
_____	_____

SDMI STEINBERG DIAGNOSTIC

Intake Questionnaire
Advanced Cardiac Imaging

Patient Information Patient Number _____ *to be filled in by tech*

First Name _____ Last Name _____ Age _____

Reason for your Exam (p*lease describe in detail)*

_____

_____

_____

TECH NOTES: *(for internal use only)*

Contrast _____

Sedation _____

Notes _____

DO YOU HAVE OR HAVE YOU HAD? (circle yes or no for all)

High Blood Pressure/Hypertension	YES	NO			
High Cholesterol	YES	NO			
Shortness of Breath	YES	NO			
Any Chest Pain	YES	NO			
Stress Test	YES	NO	Were the Results Normal?	YES	NO
Heart Bypass Surgery	YES	NO	How Many?		
Stents placed in your heart?	YES	NO	Which Vessels?		
Family history of heart disease?	YES	NO			
Taken any sexual performance drugs in last 48hrs?	YES	NO			
Diabetes	YES	NO			

Are you a smoker? Current Past Never

If yes, how many years? _____

Is your problem related to an injury? NO _____ YES _____ *(if yes continue)*

Date of Injury _____ How were you injured *(circle one)* Car Accident Work Other

Describe Injury *(please be specific)* _____

_____

Have you ever been diagnosed with cancer? NO _____ YES _____ *(if yes continue)*

What type of cancer _____ Location _____ Date Diagnosed _____

Current Status *(please circle one)* Newly Diagnosed Recurrence Remission

Treatment *(please circle all that apply)* Surgery Radiation ChemoTherapy

Date of last Treatment _____

Has it spread? NO _____ YES _____ If Yes, Where _____

Is your visit today related to this cancer diagnosis NO _____ YES _____

Previous surgeries or imaging studies related to the affected area you are being seen for today.
(please list specifically, what and when)

Procedure Description	Date
_____	_____
_____	_____
_____	_____
_____	_____

SDMI STEINBERG DIAGNOSTIC

Intake & History Questionnaire
Dexascan

Patient Information Patient Number _____ *to be filled in by tech*

First Name _____ Last Name _____ Age _____

Reason for your Exam (*please describe in detail)*

_____

_____

HISTORY (circle yes or no for each)

Are you here for a Post Menopausal Osteporosis Screening?	**YES**	**NO**
Are you taking any bone loss medeications (Boniva, Fosamax, Etc)?	**YES**	**NO**

Is there a chance that you are pregnant?	YES	NO
Have you had a barium X-Ray in the last 2 weeks?	YES	NO
Have you had a nuclear medicine test or dye injection X-Ray in the last 2 weeks?	YES	NO

If you circled yes for ANY of the above you must verbally NOTIFY the tech before your exam.

Have you ever had a bone density test?	YES	NO	When/Where: _____
Have you been diagnosed with Osteoporosis?	YES	NO	When: _____
Have you been diagnosed with low bone mass (osteopenia)?	YES	NO	When: _____
Do you take/have taken estrogen or hormone replacement?	YES	NO	Type/Dose/When: _____
Are you taking calcium/vitamin D	YES	NO	When: _____
Have you ever had surgery of the spine, hips, or arms?	YES	NO	
Do you have any metal in your backs or hips?	YES	NO	
A family history of hip fracture in patients mother or father?	YES	NO	
Taken steroid pills for 3 months or more (glucocorticoids)?	YES	NO	
History of a fracture as an adult?	YES	NO	
Ever diagnosed with a secondary osteporosis?	YES	NO	
Ever diagnosed with rheumatoid arthritis?	YES	NO	

WOMEN ONLY (circle yes or no for each)

Are you still having menstrual periods?	YES	NO	
Are you postmenopausal?	YES	NO	At what age? _____
Have you had a hysterectomy (removal of uterus)?	YES	NO	At what age? _____
Have you had both of your ovaries removed?	YES	NO	

Previous surgeries, recent hospitalization, imaging studies and other important medical conditions
(please list specifically, what and when)

Procedure Description	Date
_____	_____
_____	_____

Patient Signature: _____ **Todays Date:** _____

TECH NOTES: *(for internal use only)*

Notes _____

SDMI STEINBERG DIAGNOSTIC

Intake & History Questionnaire
Mammography

Patient Information Patient Number _____ *to be filled in by tech*

First Name _____ Last Name _____ Age _____

Reason for your Exam (*please describe in detail)*

_____

_____

Do You have any of the following complaints? (circle yes or no for each)

Breast Tenderness/Pain	YES	NO	RIGHT	LEFT	BILATERAL	
Lumps?	YES	NO	RIGHT	LEFT	BILATERAL	How Long: _____
Nipple Discharge?	YES	NO	RIGHT	LEFT	BILATERAL	Color: _____
Nipple Retraction	YES	NO	RIGHT	LEFT	BILATERAL	How Long: _____
Skin Dimpling	YES	NO	RIGHT	LEFT	BILATERAL	How Long: _____
Is this your first Mammogram?	YES	NO	If no, when/where was your last: _____			

Have you had a breast ultrasound?	YES	NO	When/Where: _____
Are you pregnant?	YES	NO	If YES, MUST inform technologist before exam.
Are you still having menstrual periods?	YES	NO	Date of Last period: _____
Have you ever been pregnant?	YES	NO	Age of first pregnancy/birth: _____
Are you taking hormones or birth control?	YES	NO	Type/How Long: _____
Do you have breast implants?	YES	NO	Saline Silicone Date implanted: _____
Smoking?	YES	NO	

Breast Cancer History

Family history of breast cancer? NO YES (*if yes continue)*

Sister Daughter Mother Grandmother Other _____

Personal history of breast cancer? NO YES (*if yes continue)*

What type of breast cancer _____ Location _____ Date Diagnosed _____

Current Status *(please circle one)* Newly Diagnosed Recurrence Remission

Treatment *(please circle all that apply)* Surgery Radiation ChemoTherapy Tamoxifen Arimedex

Date of last Treatment _____ Has it spread? NO YES *If Yes, Where*

Is your visit today related to this cancer diagnosis? NO YES

Have you had previous breast surgeries, breast biopsies or breast imaging studies NO YES

Procedure Description	Date

I understand that 10-20% of all breast cancers are not visualized on mammograms. I will be responsible for follow-up with my health care provider regarding all future breast concerns.

Patient Signature: _____ **Todays Date:** _____

TECH NOTES: *(for internal use only)* Tech Initials _____ RT(R)(M)

_____

_____

Right Breast Left Breast