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 Cigarettes? YES NO Other:_____

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
_____	_____
_____	_____
_____	_____
_____	_____