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 Permanent Makeup	YES	NO	Where: _____
Clothing with Antimicrobial, Antibacterial fibers?	YES	NO	
Recent Barium Enema/UG I	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 Hypertension?	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 _____

_____

_____