ZILKHA RADIOLOGY **Copayment _____ Operator: _____**

Patient Medical History/Problem List

Referring Doctor: _____

Other Doctors you want results sent to:

_____

_____

Affix Patient Label Here

In order to provide the patient, with optimal care, Zilkha Radiology will make available reports and studies to your healthcare providers.

Height _____Weight _____ Allergy to **Latex**? **YES NO** History of Seizures? **YES NO**

Any chance you are pregnant? **YES NO** Are you currently nursing? **YES NO**

Do you have an allergy to medications or food? YES NO List:_____

SMOKING:

- ☐ Current; Every Day Smoker
- ☐ Current; Some Days Smoker
- ☐ Former Smoker
- ☐ Never Smoked
- ☐ Smoker; Current Status Unknown
- ☐ Unknown if Ever Smoker

If Smoker, how many packs per day? _____ How many years? _____

Reason why your doctor ordered this test? _____

_____

_____

BONE DENSITY (DEXA) patients only:

Do you take Calcium or a Multivitamin? **YES NO** Did you take one today? **YES NO**

(If **YES**, you must reschedule your appointment today)

Medical History (Cancer Diagnosis, Past Surgeries, Medical Conditions)	**Date**

Authorization for Treatment: I hereby consent to treatment by the Radiologist and other medical staff for all radiological tests and/or procedures as deemed medically necessary by my referring physician.

I hereby state that the information listed above is accurate to the best of my knowledge.

Patient or Legal Guardian Signature _____Date_____