ZILKHA RADIOLOGY

X-Ray/ DEXA/ Nuclear Medicine & Ultrasound – Patient Form

Office use : Co-pay ____________________PACS _______ TECH SHEET ______ EMR ________

Referring Doctor: ______________________________

Other Doctors you want your results sent to:

____

____

Affix Label Here

Height _______**Weight** _________ Allergy to **Latex**? **YES NO** History of Seizures? **YES NO**

Any Allergies to food or medication? **YES NO** List: ____

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

Reason your doctor ordered this exam? ____

____

Personal history of Cancer? **YES NO** Explain: ____

Any prior Surgery(s)? **YES NO** Explain: ____

____

Other medical conditions (i.e. Hypertension)?____

____

<u>BONE DENSITY</u> (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)

SMOKING:

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

If Smoker, How many packs per day? ___________ For how many years? ______________

Are you taking any medications? NO YES List: ____________

____

____

____

Do you have an allergy to medications?

NO YES List: ________________

____

<u>Authorization for Treatment:</u> 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.

Print Patient Name: ____ **Date of Birth:** ________________________

Patient or Legal Guardian Signature ____**Date**_______________