SDI DIAGNOSTIC IMAGING

New Patient Health Questionnaire Date:_____ New patient/Established (circle one)

NAME:_____DOB_____AGE_____SEX: M/F Marital Status: S/M/D/W

Occupation: (if retired, previous occupation)_____Disabled: Y/N Nature of disability:_____

Birthplace: _____ Height:_____ Weight:_____

Please list all your treating Physicians and their specialty:

_____ _____

_____ _____

_____ _____

What Medical Concerns brought you here?:_____

_____

What is your home environment: (e.g. live alone, with family, single parent, apartment, house, stairs, etc)_____

_____

Do you have advanced directives or a Living Will? Yes/No (if yes, which one)_____

Are you under a lot of pressure at work or home? Yes/No Which_____

List all medications including over the counter, prescription, herbal or natural remedies:

MEDICATIONS	PURPOSE	HOW OFTEN	LAST TIME TAKEN

Are you currently on any blood thinners or antiplatelet medication? YES/NO

Do you take fish oil or Omega 3? YES/NO

When was the last time you took aspirin product? (aspirin, ibuprofen, excedrin, aleve, etc)_____

ARE YOU ALLERGIC TO X-RAY CONTRAST: YES/NO (If yes, describe the reaction and when it occurred)

_____

_____

ALLERGIES:_____

_____

PREVIOUS SURGERIES/EXAMS	DATE	MEDICAL ILLNESSES/CONDITIONS	DATE

OUTPATIENT PRE PROCEDURE SCREENING SHEET

		yes	no
HEART	history of high/low BP		
	chest pain/pressure/angina		
	heart attack when:____		
	valve disease/prolapse/murmer		
	congenital heart disease		
	peripheral vascular disease		
	irregular beats/palpitations		
	pacemaker/defibrillator		
	rheumatic fever/enlarged heart		
	congestive heart failure		
	coronary stents		
RESPIRATORY	asthma/wheezing		
	bronchitis/pneumonia		
	emphysema/chronic lung disease		
	hoarseness/nasal congesion		
	stop breathing in sleep		
	shortness of breath		
	tuberculosis/+ skin test		
do you have difficulty walking up 2 flights of stairs?			
Do you smoke now or in past?			
how much: how long: stopped:			
DIGESTIVE	difficulty swallowing		
	gastritic		
	ulcers		
	hiatal hernia		
	acid reflux		
	liver problems/cirrhosis		
	hepatis A B C		
	history of diarrhea/constipation		
URINARY	difficulty urinating		
	kidney failure		
	dialysis		
	kidney stones		
BLOOD	anemia		
	bruise easily/bleed easily		
	AIDS/HIV		
	sickle cell disease/trait		
	cancer		

		yes	no
NEUROLOGIC	stoke		
	mini stroke		
	seizures		
	epilepsy		
	fainting		
	dizziness		
	heachache		
	migraines		
	numbness/tingling		
	where:		
	anxiety/panic attacks		
	depression		
	memory loss		
	head injury		
METABOLIC	diabetes		
	hypoglycemia		
	thyroid disease		
	recent weight loss/gain		
MUSCLE/JOINT	arthritis		
	joint pain		
	where		
	back pain		
	where		
	mild/moderate/severe		
	limited neck movement		
	weak muscles		
	unsteady gait		
	prosthesis		
do you drink alcohol/beer or wine how much day/week/month			
caffeine (how often)			
do you or have you done recreational drugs?			
difficulty hearing			
hearing aids			
difficulty eyesight			
glasses/contacts			
implanted devices			
congenital/genetic abnomalities			

any difficulties with medications that made you sick in the past (not allergic to)?_____

_____

St. Joseph's Hospital
BayCare Health System

MEDICAL IMAGING SERVICES

SDI PATIENT INFORMATION SHEET

Last Name:_____

First Name:_____ M.I._____

DOB:_____ Sex:_____ SS#:_____ Wt:_____ Ht._____

Phone #:_____ Cell #:_____

Address:_____

City:_____ State: FL Zip:_____

PCP:_____ Phone #:_____
(Primary Care Provider)

Insurance:

Guarantor (Relationship):_____
(Subscriber) (If patient is pediatric, write parent's name, dob, ss# in address field of Ins tab)

Insured's Name:_____

Insurance Company:_____

Policy #:_____ Effective Date:_____

Signs and Symptoms:_____

Ordering Doctor: Dr._____ Ph #: 813-870-4919

Comments:_____
(Initials of scheduler/outpatient/radiologist/scheduled date, any other notes. For invasive procedures, specify from prescription)

History:_____
(For mammograms and sonograms, write here the OR time and surgicare or same day surgery, any blood thinners, etc.)