Today's Date

____ / ____ / 20___

Interventional Radiology
Patient Information for General Procedures

Name: _____ **SS#:** _____-_____-_____

Address: _____ **Home #:** _____-_____-_____

_____ **Work/Cell #:**_____-_____-_____

Which number do you prefer us to call? Home Work Cell Any **May we leave a message?** Y N

DOB: _____/_____/_____ **Marital Status:** S M D W

Family Physician: _____ **PCP Phone #:** _____-_____-_____

Emergency Contact: _____ **Home #:** _____-_____-_____

Relationship: _____ **Cell/Work#:** _____-_____-_____

Insurance: _____ **ID#:** _____

Subscriber's Name: ☐ Self (if self go to Medical & Family History) _____

Relationship: Spouse Parent Other **DOB:** _____/_____/_____ **SS#:** _____-_____-_____

Address: _____

****If you have a secondary insurance please inform the receptionist! You do not have to list on this form. ****

Medical & Family History

Do you or a family member have or ever had any of the following conditions? Please specify below by checking **Y** for yes, **N** for no & **FAM** if you have a family history.

	Y	N	FAM		Y	N	FAM
Anemia				Kidney Disease			
Asthma				Intestinal Disease			
Arthritis				Shortness of Breath			
Bleeding Disorder				Enlarged Lymph Nodes			
Cancer				Lung Disease (COPD, CHF)			
Cataracts/Glaucoma				Swelling of Extremities			
Dizziness/Fainting				Poor Circulation			
Seizures/ Epilepsy				Stomach Ulcers			
Goiter/Thyroid Disease				Stroke			
Gout				Osteoporosis			
Head Injury				Multiple Myeloma			
Heart Disease/Pacemaker				Pheochromocytoma			
High Cholesterol				Headaches			
Hypertension				Hernia			
Hepatitis/Liver Disease				Other:			
Anxiety/Panic Attacks							
Diabetes Do you take Glucophage? Y / N							

Do you smoke? Y N **Use Alcohol?** Y N **Use Recreational Drugs?** Y N

Surgical History
Please list any surgical procedures you have had performed.

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Medications
Please List any current medications including vitamins, herbal supplements, prescription and over the counter.

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

Allergies
Please circle yes or no to the following questions and then list any additional allergies.

Are you allergic to **x-ray dye**? Y / N **Latex**? Y / N **Betadine**? Y / N

1. _____ 2. _____ 3. _____ 4. _____

Current Illness
What are the symptoms that led you to this referral?

_____
_____
_____
___

What treatments have you had for this problem?

_____
_____
_____
___

Has your workup **for this specific problem** included any of the following tests?

Test	Y	N	Date	Where
Angiogram				
X-Rays (plain films)				
CAT Scan				
MRI				
Ultrasound				
PET Scan				
Nuclear Bone Scan				

Physician Signature: _____ **Date:** _____/_____/_____