ZOOM DIAGNOSTIC IMAGING

Patient Questionnaire

Which body part(s) will be examined today?

Abdomen ☐	Cervical Spine/Neck ☐		Foot	Right ☐	Left ☐	Lower Leg	Right ☐	Left ☐
Brain ☐	Thoracic Spine ☐		Forearm	Right ☐	Left ☐	Shoulder	Right ☐	Left ☐
Chest ☐	Lumbar Spine ☐		Hand	Right ☐	Left ☐	Thigh	Right ☐	Left ☐
Jaw ☐	Ankle	Right ☐	Left ☐	Hip	Right ☐	Left ☐	Wrist	Right ☐	Left
Pelvis ☐	Elbow	Right ☐	Left ☐	Knee	Right ☐	Left ☐			

Explain your medical problems that are the reason for having this MRI/CT/Ultrasound/X-Ray _____

_____

How long have you had this problem? _____

Have you had a recent injury/trauma to this area? _____

List all other medical problems _____

List previous surgeries and dates of surgery to the area of concern _____

Specify if you have had any previous physical/conservative therapy _____

Specify if you have been treated for any medical illness or disease _____

Please list all allergies _____

****FEMALE PATIENTS ONLY****

Is there any possibility of pregnancy? ☐ Yes ☐ No When was the first day of your last menstrual cycle? _____

Have you had intercourse since the first day of your last menstrual cycle? ☐ Yes ☐ No

Are you using birth control or have had a hysterectomy/tubal ligation? (please specify) _____

I authorize Zoom Diagnostic Imaging to perform all diagnostic procedures that were ordered for me by my physician. I hereby release Zoom Diagnostic Imaging from any and all liability pertaining to the performance of diagnostic imaging procedures. Furthermore, I understand and agree that Zoom Diagnostic Imaging is released from all liability and litigation pertaining to myself, and/or my unborn child. I have been informed of the current risks to myself and to my unborn child (if pregnant) if exposed to radiation from a CT scan, X-Ray and/or Oral contrast. While it is currently accepted that ultrasound and MRI are not proven to be harmful to an unborn child, if complications arise, I fully understand and agree to release Zoom Diagnostic Imaging from any and all liabilities.

Patient Signature: _____ Date: _____

Please check the box if you have a history or currently have any of the following:

☐ Yes ☐ No	Diabetes		☐ Yes ☐ No	Heart Block, Heart Attack, Heart
☐ Yes ☐ No	Kidney Failure, Renal Disease, Renal Surgery		☐ Yes ☐ No	Disease
☐ Yes ☐ No	Sickle Cell Anemia		☐ Yes ☐ No	Ventricular Tachycardia
☐ Yes ☐ No	Pain Numbness/Weakness in Upper Extremity	☐ Left ☐ Right	☐ Yes ☐ No	Sino Arterial Dysfunction
☐ Yes ☐ No	Pain Numbness/Weakness in Lower Extremity	☐ Left ☐ Right	☐ Yes ☐ No	Seizures
☐ Yes ☐ No	Multiple Myeloma		☐ Yes ☐ No	Headaches
☐ Yes ☐ No	Cancer		☐ Yes ☐ No	Dizziness
☐ Yes ☐ No	Chemotherapy or Radiation		☐ Yes ☐ No	Severe Debilitation
☐ Yes ☐ No	Pulmonary Hypertension		☐ Yes ☐ No	Memory Loss

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Patient Signature: _____ Date: _____