# MEMORIAL RADIOLOGY ASSOCIATES, LLC - QUESTIONNAIRE FORM

Patient Name: ___________________________________________ Height/Weight: ______________________________

**Please indicate if you have any of the following: (Circle all Yes or No)***

**Reason for exam and/or Symptoms**: _________________________________________________________________

**Prior Surgeries relate to exam** (specify type and date):_____________________________________________________________

**Anything in your body that you were not born with?** (ex. pacemaker, clips and etc.): Yes No If yes, explain?

_______________________________________________________________________________________________________________

**Have you had a previous imaging performed of this body part?** Yes No

If yes, when and where was it performed? __________________________________________________________________________

**History of cancer?** Yes No

If yes, please specify type and date of diagnosis? ____________________________________________________________________

**Were you treated with Chemotherapy or Radiation?** Yes No

If yes, please specify type and date of last treatment: _________________________________________________________________

**Female Patients Only:** I could be pregnant. Yes No Breastfeeding Yes No My last menstrual period date: __________

**I attest that the information is correct to the best of my knowledge. I read & understand the contents of this form & had the opportunity to ask questions regarding the information on this form & regarding the procedure that I am about to undergo**.

__________________________________________ ______________________________ Date _____/_____/_____

Patient/Parent/Legal Guardian Signature Relationship

## CONTRAST IV INJECTION

**Are you allergic to any medication?** Yes No **Are you allergic to any foods?** Yes No

If yes, please list and describe reaction: ______________________________________________________________________________

**Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination?** Yes No

If yes, describe reaction: __________________________________________________________________________________________

**Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, or liver (hepatic) disease?** Yes No

If yes, please describe: ___________________________________________________________________________________________

**Are you diabetic?** Yes No If yes, what medication are you taking? ____________________________________________________

**Are you on dialysis?** Yes No **Have you ever smoked?** Yes No **Have you eaten in the last 4 hours?** Yes No

**Your doctor has asked that this exam be performed using intravenous contrast material. If you have any questions, you will be able to speak to the technologist.**

**I understand as with administration of any medication there is a possibility of an allergic reaction.**

__________________________________________ ______________________________ Date _____/_____/_____

Patient/Parent/Legal Guardian Signature Relationship

Advanced Directive/ Living will? Yes No (If yes, please provide a copy to the technologist so we can respect your wishes)