Outpatient Diagnostic Center of Knoxville

PATIENT CONSOLIDATED HISTORY AND SCREENING FORM

Patient Information

Date: ______________

Patient Name: ______________________ Sex: ☐ M ☐ F Weight: __________ Height: ________

MRN: ____________ DOB: ____________ Age: _____ Procedure: ____________________

Referring Physician: ______________ Are you pregnant? ☐Yes ☐No Date of last period: ________

Reason you are here today for an exam? Explain your medical problem in detail. (What is the Problem?

Where is the problem? How long have you had this problem?) ______________________________

Have you had a previous imaging study related to this problem (x-ray, ultrasound, CT, MRI)? ☐ Yes ☐ No

If yes, please explain:

What exam? ______________ When? ____________ Name of facility: ______________

List other medical problems: ______________________________

List previous surgeries: ______________________________

Medications you are presently taking: ______________________________

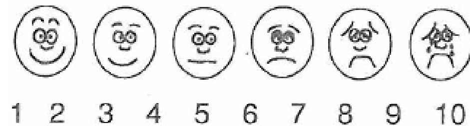
List any drug or food alergies: ______________________________

Do you smoke? ☐ Yes ☐ No If yes, # of years: ________ Packs per day: ________

Do you have pain? ☐ Yes ☐ No ☐ N/A

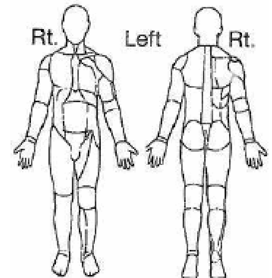
How long have you had pain?

Pain Rating/Intensity:



1 2 3 4 5 6 7 8 9 10

Draw on the figures where the pain/symptoms are located:



Contrast Exams Only ☐ ***Not Applicable***

Are you taking Metformin hydrochloride (Glucophage, Glucovance, Avandement, Metaglip, Fortamet)? ☐Yes ☐No

Hare you ever had a previous allergic reaction to x-ray contrast (dye)? ☐Yes ☐No

If yes, explain: ______________________________

Any personal history of:

☐Yes ☐No Headaches
☐Yes ☐No Liver Disease
☐Yes ☐No Diabetes
☐Yes ☐No Stroke
☐Yes ☐No Asthma
☐Yes ☐No Allergic Respiratory Disease
☐Yes ☐No Dizziness
☐Yes ☐ No Are you breast feeding at this time?

☐Yes ☐No Kidney Disease/Kidney Failure
☐Yes ☐No Are you on Dialysis?
☐Yes ☐No Bladder Disease
☐Yes ☐No Cancer
☐Yes ☐No Heart Disease
☐Yes ☐No Prostate Problems
☐Yes ☐No Seizure Disorder
☐Yes ☐No Multiple Myeloma
☐Yes ☐No Blood Disorder/Sickle Cell

If yes, please explain: ______________________________

Comments: ______________________________

FOR MRI ONLY ☐ ***NOT APPLICABLE FOR THIS EXAM***

WARNING: Certain implants and devices may be hazardous to you and/or may interfere with the MRI procedure. If you have any implants or devices, DO NOT ENTER the MRI Room without discussing this with the MRI Technologist. The MR system magnet is ALWAYS on.

Do you have any of the following?

☐ Yes ☐ No Heart Surgery/Heart Valve/Pacemaker. If yes, explain: ______

☐ Yes ☐ No Brain Surgery/Brain Aneurysm Clips. If yes, explain: ______

☐ Yes ☐ No Shunts/Stents/Intravascular Coil. If yes, explain: ______

☐ Yes ☐ No Eye Surgery/Implants. If yes, explain: ______

☐ Yes ☐ No Injury to eye involving metal or metal shavings. If yes, explain: ______

☐ Yes ☐ No Penile Prosthesis. If yes, explain: ______

☐ Yes ☐ No Orthopedic pins, screws, rods, etc. If yes, explain: ______

☐ Yes ☐ No Neurostimulator/Biostimulator. If yes, explain: ______

☐ Yes ☐ No Radiation Therapy/Chemo Therapy. If yes, explain: ______

☐ Yes ☐ No History of Cancer or Tumors. If yes, explain: ______

☐ Yes ☐ No Previous back surgery (neck/back). If yes, explain: ______

☐ Yes ☐ No Ear Surgery/Cochlear Implants/Hearing Aids. If yes, explain: ______

☐ Yes ☐ No Diaphram/IUD/Pessary. If yes, explain: ______

☐ Yes ☐ No Metal mesh implants/wire sutures/wire staples/Internal electrodes. If yes, explain: ______

☐ Yes ☐ No Any electrical, mechanical, or magnetic implants. If yes, explain: ______

☐ Yes ☐ No Implanted drug infusion pump/insulin pump. If yes, explain: ______

☐ Yes ☐ No Implanted cardiac defibrillator. If yes, explain: ______

☐ Yes ☐ No Pacing wires, Swann GANZ Catheter ______

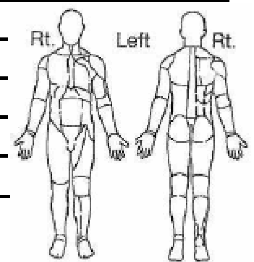
☐ Yes ☐ No Tattoos/Permanent make-up/Body piercings. If yes, explain: ______

☐ Yes ☐ No Dentures, partials, or dental implants. If yes, explain: ______

☐ Yes ☐ No Gunshot wounds, shrapnel, BBs. If yes, explain: ______

☐ Yes ☐ No Vascular Access Port. If yes, explain: ______

☐ Yes ☐ No Medication patch? If yes, explain: ______



Draw on the figures the location of any metal in your body:

Acknowledgement: I have answered these questions to the best of my knowlegdge and understand the information presented to me. I have also informed the technologist that I am not pregnant at this time. I give consent to the performance of a/an ______ at Outpatient Diagnostic Center.

Patient/Parent/Guardian Signature	**Technologist/Witness Signature**	**Date**

FOR CLINICAL USE ONLY

Patient Education given: ☐ Verbal ☐ Brochure ☐ Video Identity: ______

Patient Shielded: ☐ Yes ☐ No ☐ N/A BUN ______ Creatinine ______ GFR ______

CONTRAST ADMINISTRATION ☐ ***NOT APPLICABLE TO THIS EXAMINATION***

______ CC of ______ with a ______ @ ______

Amount / Type of Contrast / Guage & needle type / Time

X______ in ______ Lot # ______ Expiration date: ______

# of punctures / site location

Power injector used? ☐ Yes ☐ No Rate: ______ cc per ______ seconds

Discharge Instructions Given? ☐ Yes ☐ No ☐ Form #: ______