IMAGING SCREENING QUESTIONNAIRE

The purpose of this questionnaire is for our providers to refer patients to outside facilities for imaging, injections, physical therapy, surgeries, etc. therefore we want to capture this information to be able to assist in scheduling.

PLEASE ANSWER ALL QUESTIONS BELOW:

1. Approximate weight? _______
2. Height? _______
3. Are you diabetic? ☐ **YES** ☐ **NO**
   If **YES**, do you have an insulin pump? ☐ **YES** ☐ **NO**
   Do you take medications? ☐ **YES** ☐ **NO**
   Do you have a glucose monitor or patches? ☐ **YES** ☐ **NO**
4. Do you have a history of kidney disease or currently on dialysis? ☐ **YES** ☐ **NO**
5. Do you have any history of chemotherapy? ☐ **YES** ☐ **NO**
   If **YES**, when? ________
6. Do you have an allergy to latex? ☐ **YES** ☐ **NO**
7. Do you have an allergy to MRI contrast? ☐ **YES** ☐ **NO**
8. Do you have an allergy to CT contrast? ☐ **YES** ☐ **NO**
9. Are you currently taking blood thinning medication? ☐ **YES** ☐ **NO**
10. Are you claustrophobic? ☐ **YES** ☐ **NO**
    If **YES**, will you need a sedative? ☐ **YES** ☐ **NO**
11. Have you had any spine fusions? ☐ **YES** ☐ **NO**
    If **YES**, what part of spine and what year was fusion done?
    Spine Levels: ____________ Date: __________
12. Have you ever worked with metal (welder, machinist, etc.)? ☐ **YES** ☐ **NO**
    If **YES**, when: __________
13. Do you have any implants in your body? ☐ **YES** ☐ **NO**
    If **YES**, please **circle** any of the following:
    Joint replacements, pain pump, pacemaker, defibrillator/ICD, stents in heart, valves, spinal cord stimulator.
    Other: ________________
    For **ANY implanted devices that have a model/serial number, please provide information.
    Implant information: _________________________________
    *** **(If applicable please bring copy of implant card to appointment)** ***
14. Will you need any assistance to get on and off the exam table? ☐ **YES** ☐ **NO**
    If **YES**, will you need a hoyer lift? ☐ **YES** ☐ **NO**