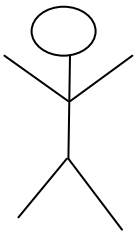
Lake Medical Imaging

Accredited by the American College of Radiology

For office use only: B/P: _____ Pulse: _____ Height: _____ Weight: _____ BMI: _____

Physician Notes:

Present Findings: Imaging Studies: Physical Exam:



PLEASE COMPLETE IN ADVANCE AND BRING IT WITH YOU ON THE DAY OF YOUR APPOINTMENT.

Patients Name_____What Doctor is referring you to us?_____

SS# _____Who is your primary care Physician? _____

Why are you coming for a consult? What kind of a problem are you having?

_____

_____

_____

What medical problems do you currently have or have you had in the past?

_____

_____

What surgeries have you had, and when were they performed?

_____

_____

Please check off (√) any problems that you are having now:

General
( ) Chills
( ) Weight Loss

Neurological / Psychological
( ) Headaches
( ) Weakness
( ) Speech Changes
( ) Confusion
( ) Anxiety
( ) Depression
( ) Numbness/Tingly

Ears, Nose, Throat
( ) Visual changes
( ) Vision loss
( ) Hearing changes

Other
( ) Trauma_____

Respiratory
( ) Cough
( ) Shortness of breath
( ) Difficulty breathing on exertion
( ) Coughing up blood

Cardiac
( ) Chest pain
( ) Palpitations
( ) Leg swelling
( ) Difficulty sleeping flat

Gastrointestinal
( ) Nausea and/or vomiting
( ) Constipation
( ) Diarrhea
( ) Bloody stools
( ) Black tarry stools

Extremities
( ) Pain when walking
( ) Discoloration
( ) Pain at rest
( ) Ulcers
( ) Swelling of extremities
( ) Varicose veins

Urinary
( ) Difficulty urinating
( ) Frequent urination
( ) Painful urination
( ) Blood in urine

Skin
( ) Bruising
( ) Rash
( ) Itching

Please list all Drug Allergies:

_____

_____

Patient Medication List:

To ensure the highest quality care for our patients, we ask you to complete the following medication list to assure that we are as informed about your healthcare as possible.

Prescriptions						
Brand or Generic Name	**Dose (total mg)**	**How often do you take this Rx?**	**When do you take it (time of day)? With or without meals?**	**Who is the prescribing Physician?**	**What is it taken for?**	**Have you experienced any side effects to this medication? If so please explain…**

Over-the-counter medications, herbal remedies, vitamins						

Social History:

Do you smoke?_____ If yes, how many packs per day?_____ For how many years?_____

When did you quit?_____

How much alcohol do you drink (drinks per week)?_____

Marital status: Single_____ Married _____ Divorced_____ Widowed_____

Live alone (circle one) Yes No

Do you exercise? How many times per week? _____ For how long? _____

Family History (please list disease that your family member had or has died of):

Father: _____
Mother: _____
Sister(s): _____
Brother(s):_____

Prior Radiologic studies (x-rays, ultrasound, CT, MRI, arteriograms, etc.) (When & Where)

_____
_____
_____
_____
_____
_____

How did you hear about Lake Medical Imaging?

_____
_____
_____

_____ _____

Patient Signature **Date**