Manatee Diagnostic Center

MEDICAL HISTORY

DID YOU HAVE OR DO YOU NOW HAVE ANY OF THE FOLLOWING:

			ALLERGIC RHINITIS	YES	NO
ANAPHYLACTIC SHOCK	YES	NO	ARTHRITIS	YES	NO
ANGIONEUROTIC EDEMA (SEVERE SWELLING OF THE EXTREMETIES)	YES	NO	ASTHMA	YES	NO
BLEEDING DISORDER	YES	NO	BLOOD CLOTS	YES	NO
CONGESTIVE HEART FAILURE	YES	NO	CIRCULATION PROBLEMS	YES	NO
GOUT	YES	NO	HEART DISEASE	YES	NO
HEPATITIS	YES	NO	HIGH BLOOD PRESSURE	YES	NO
LUPUS	YES	NO	MULTIPLE MYELOMA	YES	NO
RECENT DEHYDRATION	YES	NO	RENAL INSUFFICIENCY	YES	NO
RHEUMATIC FEVER	YES	NO	SCLERODERMA	YES	NO
SEIZURE DISORDER	YES	NO	STROKE	YES	NO
SICKLE CELL DISEASE	YES	NO	THYROID DYSFUNCTION	YES	NO

BLADDER OR KIDNEY DISEASE YES NO

DO YOU HAVE HISTORY OF ONLY ONE FUNCTIONING KIDNEY? YES NO
HAVE YOU HAD SURGERY TO REMOvE A KIDNEY? YES NO
HAVE YOU HAD A KIDNEY TRANSPLANT? YES NO

HEIGHT: _____

WEIGHT: _____

CANCER YES NO STILL RECEIVING TREATMENT? YES NO

LOCATION _____

DIABETES YES NO TYPE 1 or TYPE 2 INSULIN or ORAL MEDS

DO YOU TAKE DIURETICS(WATER PILLS)? YES NO

DO YOU HAVE A HISTORY OF ADVERSE REACTION TO CONTRAST MATERIAL (WITH THE EXCEPTION OF HEAT OR FLUSHIING SENSATION OR SINGLE EPISODE OF NAUSEA OR VOMITING) YES NO

DO YOU HAVE A HISTORY OF SERIOUS REACTION TO FOODS OR OTHER MEDICATIONS? YES NO

PLEASE LIST ALL SURGERIES YOU HAVE HAD IN YOUR LIFETIME (ATTACH ADDITIONAL PAGE IF NEEDED)

Current Smoker: YES NO How many packs per day? _____

Former Smoker: YES NO How many years smoking? _____

Are you interested in smoking cessation or Lung Cancer screening? YES NO

FOR ALL FEMALE PATIENTS: IS THERE A POSSIBILITY OF PREGNANCY? YES NO

LAST MENSTRUAL PERIOD WAS: _____

PATIENT SIGNATURE: _____ **DATE:** _____