



\*DT0002\*



ST. LUKE'S

PATIENT INFORMATION DEPARTMENT OF RADIOLOGY

Diagnostic & Treatment Center Kirby Glen

Patient's Name: Date: Time:

Height: ft. inches Weight: lbs/kg. Last time you ate or drank: am / pm

Have you ever had a CT Scan, IVP/Kidney study, Angiogram or MRI procedure before? Yes No

If so, did you receive contrast? Yes No How did it make you feel?

Did you bring any x-ray films/pictures with you today for review and/or comparison? Yes No

Facility where previous imaging studies were performed: Date performed:

Are you pregnant? Yes No Are you lactating? Yes No Date of last menstrual period:

Did you bring any lab/blood test results with you today? Yes No

For patients undergoing Cardiac Stress Testing: Have you had any caffeinated/decaffeinated products within the past 12 hours (i.e. soda, diet soda, chocolate, strawberries, tea)? Yes No

List any known medication or food allergies:

- No known drug allergies, No known allergy to iodine, No known allergy to MRI dye, Penicillin, Latex, Sensitivity to tape, No known food allergies

Yes, I have allergies: please list and describe reaction in the space provided below:

Table with 2 columns for listing allergies and reactions.

I DO NOT TAKE ANY MEDICATIONS

Table with 6 columns: Name of Medication, Reason for Use, Dose/Strength, How often taken, Date and time of last dose, Staff use only Reviewed on Admission.

PAIN:

Do you have any pain? Yes No If yes, where is your pain located?

Please describe your pain:

\*Rate your pain on scale of 0-10 (0 no pain) Pain you have now (0-10) Usual pain (0-10)

Comfort Goal: Is your pain control satisfactory? Yes No If no, please explain:

Medical History: None

- Asthma/Lung problems, Blood/Coagulation problems, Cancer, Congestive Heart Failure, Coronary Artery Disease, Chest Pain, Diabetes, Kidney failure, Dialysis, Hysterectomy, Seizures, Sickle Cell, Stroke, TB, Tobacco use, Alcohol Use

Surgeries and Invasive Procedures: I have not had any surgery or procedure Yes, I have had surgery and/or procedures, please list procedure and date

Other: Is there any additional information we should know that was not specifically asked elsewhere on the database?

Completed by: Relationship to patient: Phone # of driver:

Reviewed by: RN / Technologist Date: Time: