NorthwestRadiologyNetwork
"Trusted Imaging Since 1967"

Medical Imaging Questionnaire

Patient ID

Facility:_____ Phone:_____ *Pregnant / Breast Feeding: Yes❑ No❑ *Insulin Pump: Yes❑ No❑

*Is there any reason why you cannot proceed with this exam today? Yes❑ No❑ If answered yes, please consult the ordering physician.

History:

Exam(s):_____

Physician Indication:_____ Any Relevant Outside Study: Yes❑ No❑

Signs / Symptoms / Trauma: (cause, location, laterality, description, duration, hx of fracture, etc.) _____

_____

_____ History of smoking: Yes❑ No❑

Surgery Hx:

Within the Past 30 Days Yes❑ No❑

Surgery:_____ Date:_____

(Relevant to the examination being performed)

Appendix Removed Yes❑ No❑ Date:_____

Gall Bladder Removed Yes❑ No❑ Date:_____

Hysterectomy Yes❑ No❑ Date:_____

Uterus Removed Yes❑ No❑ Date:_____

Ovaries Removed: 1 / 2 L / R Date:_____

Surgery:_____ Date:_____

Surgery:_____ Date:_____

Cancer Hx:

Lung: Yes❑ No❑ Date:_____

Chemo Date:_____ Radiation Date:_____

Breast: Yes❑ No❑ Date:_____

Chemo Date:_____ Radiation Date:_____

Colon: Yes❑ No❑ Date:_____

Chemo Date:_____ Radiation Date:_____

Cancer: Yes❑ No❑ Date:_____

Chemo Date:_____ Radiation Date:_____

Cancer:_____ Date:_____

Chemo Date:_____ Radiation Date:_____

Additional Comments:

_____

_____

RN / RT Printed Name:_____ Date:_____ Time:_____

Pre Exam:

*Allergies:_____

Pre Procedure Instructions Followed: Yes❑ No❑ Procedure / Instructions Explained and Understood by Patient / Family ❑

*Previous Reaction To Contrast or Iodine: Yes❑ No❑ Pre-Medicated: Yes❑ No❑ Hydration: Yes❑ No❑

Pre Labs: None Ordered❑ Age:_____ Weight (kg):_____ CR:_____ *GFR:_____ GFR Verified By:_____

Diabetic: Yes❑ No❑ *Metformin Containing Medication: Yes❑ No❑ Metformin Discharge Instructions: Yes❑ No❑

Renal Disease: Yes❑ No❑ Dialysis: Yes❑ No❑ Next Date:_____ (MRI) If Dialysis over 24 hrs: Approved By Dr. _____

Exam:

Location of IV:_____ Gauge:_____ Power PICC / Port ❑ Started By:_____ Verified By:_____

Other Contrast Type:_____ Amount:_____ ml Route:_____ Time of Admin:_____

IV Contrast Type:_____ Amount:_____ ml Rate:_____ Time of Injection:_____

*Contrast Reaction: Yes❑ No❑ Medication / Amount Administered:_____

Nuclear Pharmaceuticals:_____ Administered By:_____ Time of Admin:_____

Post Exam:

*Extravasation: Yes❑ No❑ Radiologist Contacted: Yes❑ No❑ Radiologist:_____

Post Discharge Instructions / Waiver Given: Yes❑ No❑ Type:_____

Fluoro Time:_____ Dose:_____mSv Tech Performing Exam:_____ Date:_____ Time:_____

MEDICAL IMAGING QUESTIONNAIRE