

Drucker, Genuth & Augenstein, M.D.'s
516 - 766 - 1700

Date: _____ Referred by: _____
Patient No: _____ Ref. Tel #: _____ Ref Fax #: _____
Home Tel #: _____ Ref. Addr: _____
Type of Study: _____ CT/ST/ZP: _____
Patient D.O.B.: _____

What were the symptoms or medical condition that caused you to seek medical attention related to this condition?

Do you have any drug or food allergies? Yes No
List: _____

Are you allergic to iodine? Yes No

Have you ever had an X-ray exam with an injection of intravenous contrast material (dye)? Yes No
If yes, any unpleasant reaction? _____

Do you have any of the following:
_____ Asthma _____ Heart Disease
_____ Hay Fever _____ Lung Disease
_____ Diabetes _____ Kidney Disease

Diabetic Patients: Do you take Glucophage or Metformin? Yes No
If yes, date last dose taken: _____

Have you had any past surgery? Yes No
If yes, which of the following: Include date(s) of surgery

Date(s): _____	Brain	Date(s): _____	Abdomen (Specify)
Date(s): _____	Spine Lumbar	Date(s): _____	Kidney
Date(s): _____	Spine Cervical	Date(s): _____	Heart
Date(s): _____	Spine Thoracic	Date(s): _____	Hysterectomy
Date(s): _____	Knee (R or L)	Date(s): _____	Shoulder (R or L)
Date(s): _____	Other	Date(s): _____	Sinus

Female patients:
Is there any chance that you are pregnant? Yes No

Ultrasound patients:
If pregnant, date of first day of last menstrual period: _____

MRI patients:
Do you have any of the following?
_____ Pacemaker _____ Shrapnel
_____ Aneurysm Clips _____ Neurostimulator Devices
_____ Cardiac Stents _____ Metal Implants
_____ Pessary

Have you ever been a metal worker? Yes No

DIAGNOSIS: _____