South Shore Radiology
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.:

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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 Metphormin? 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

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DIAGNOSIS:_____