DIAGNOSTIC IMAGING
CENTERS, P.A.

Patient Screening Form

Office Use only
Creatinine __________mg/dl
eGFR______________ml/min/1.73m^2

Patient Information

Name:____ Date:________________________

Age:____________________ Date of Birth:____________________ Weight:______________________

❑Male ❑Female Body part to be examined:____

Reason for exam and/or symptoms:____

How long have you had symptoms?____

Medical Information

1. Have you had a reaction to a contrast medium or dye used for imaging? ❑Yes ❑No
   If yes, have you been premedicated? ❑Yes ❑No
2. Have you had a prior imaging study (MRI, CT, Ultrasound, X-ray, etc.)? ❑Yes ❑No
3. Have you had a prior cystoscopy or endoscopy? ❑Yes ❑No
4. List prior surgeries:
   Type of Surgery:____ Date:________________________
   Type of Surgery:____ Date:________________________
   Type of Surgery:____ Date:________________________
   Type of Surgery:____ Date:________________________
5. Do you have: ❑ diabetes ❑ vasculitis ❑ high blood pressure ❑ renal disease/disorder
   ❑ asthma ❑ multiple myeloma ❑ pheochromocytoma ❑ heart disease/disorder
   ❑ lupus ❑ respiratory disease ❑ sickle cell anemia/trait ❑ congestive heart failure (CHF)
   ❑ systemic lupus erythematosus (SLE) ❑ liver failure
   ❑ allergies ______________________ ____________________ __________________________
   ______________________ ____________________ __________________________
6. Do you take Actoplus Met (XR), Avandamet, Dianben, Diabex, Diaformin, Fortamet, Glucophage (XR), Glucovance, Gluformin, Glumetza, Invokamet, Janumet (XR), Kombiglyze (XR), Metaglip, Metformin, Obimet, Prandimet, or Riomet?
   ❑Yes ❑No
7. List current or recently taken medication and doses:____ ❑Unknown
   ____
8. Smoking status: ❑ Never ❑ Decline to state ❑ Current ❑ Former
   If current or former smoker: how many packs per day_______ for how many years_________
9. Do you have a personal history of cancer? ❑Yes ❑No
   If yes, describe type:____
   Describe current or past treatments: (i.e. radiation or chemotherapy) __________________________
   Date of treatment: ____
10. Please list any additional information you feel pertinent to today's exam:________________________

****Please complete and sign back of form****

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For Female Patients Only

1. Date of last menstrual period: ___________________________ Post Menopausal? ❑Yes ❑No
2. Are you pregnant or experiencing a late menstrual period? ❑Yes ❑No
3. Hysterectomy? ❑Yes ❑No
   If yes, was it a complete hysterectomy? (removal of ovaries and uterus) ❑Yes ❑No
   Date of surgery: _____________________________________
4. Are you taking oral contraceptives or receiving hormonal treatment? ❑Yes ❑No
5. Are you currently breastfeeding? ❑Yes ❑No

Medical Records Release

Please sign the medical release below.
This allows our facility to obtain your previous exams or prior medical history as it pertains to today's exam.

Submitted to: ____
Name of facility

____

____

Patient Name: ____

Social Security #: _______________________________________ Date of Birth: __________________________________

Type of records requested: ____

I hereby authorize and request you to release the complete medical records mentioned above, including copies of the reports in your possession to Diagnostic Imaging Centers, PA.

____ ____
Patient or Authorized Person Date

Patient Signature

Patient Signature______________________________________ **Date**____

Technologist____ **Technologist**____________________________________

Staff Use Only

Staff Notes: ____

____

Staff Signature: ____ **Date:** _______________________________________

❑ **Independence** • 4911 S. Arrowhead Dr • Suite 100 • Independence, MO 64055 • 816-795-7040 • (fax) 816-795-0821
❑ **Lee's Summit** • 301 NE Mulberry St • Suite 100 • Lee's Summit, MO 64086 • 816-554-0040 • (fax) 816-554-9657
❑ **Plaza** • 4801 Main St • Suite 200 • Kansas City, MO 64112 • 816-561-5151 • (fax) 816-841-0373
❑ **North** • 5400 N. Oak Trfy • Kansas City, MO 64118 • 816-455-5959 • (fax) 816-455-3728
❑ **Olathe** • 13795 S. Mur-Len Rd • Suite 100 • Olathe, KS 66062 • 913-397-7272 • (fax) 913-397-7373
❑ **Overland Park** • 6650 W. 110th St • Suite 100 • Overland Park, KS 66211 • 913-491-9299 • (fax) 913-491-9363