MANHATTAN DIAGNOSTIC RADIOLOGY

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CT ANGIOGRAPHY / CARDIAC NUCLEAR STUDY INTAKE FORM

Please print legibly

Date: ___ / ___ / ___ **Name:** ____

Last Name *First Name* *Middle Initial*

Date of Birth: ___ / ___ / ___ ______ ______ ______ **Test scheduled:** ____________________

Age *Height* *Weight*

EMERGENCY CONTACT INFORMATION

Name: ______________________________ Relationship: ____________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Why did your doctor order this test: ____

List previous tests performed at Manhattan Diagnostic Radiology and when they were performed: ______________

____

List previous surgical procedures and date performed: ________________________________

____

Do you have any of the following allergies?

Intravenous contrast (dye injection)? ☐ Yes ☐ No Latex? ☐ Yes ☐ No

Medication/Food Allergies? ☐ Yes ☐ No If yes, list : ____________________

Are you Diabetic? ☐ Yes ☐ No

If so, are you currently taking Glucophage (Metformin), Avandamet or Glucovance? ☐ Yes ☐ No

If you take the above medication, and are having a CTA, you may be asked to stop medication 24-48 hours after the test is completed.

Do you smoke? ☐ Yes ☐ No If yes, how much? _______ **Did you smoke?** ☐ Yes ☐ No When did you quit? ______

Do you exercise? ☐ Yes ☐ No If yes, how often? _______ Type of exercise? ____________________

Do you have any of the following: If yes, what medications so you take for this condition?

Kidney Disease? ☐ Yes ☐ No ____________________

Elevated Blood Pressure? ☐ Yes ☐ No ____________________

Asthma or Lung Disease? ☐ Yes ☐ No ____________________

Have you ever had:

Heart Attack / Heart Failure ☐ Yes ☐ No Year ____ Known Heart Disease ☐ Yes ☐ No Year ____

Abnormal EKG ☐ Yes ☐ No Year ____ Abnormal Stress Test ☐ Yes ☐ No Year ____

Angiogram / Cardiac Cath ☐ Yes ☐ No Year ____ Stent Placement / Angioplasty ☐ Yes ☐ No Year ____

Bypass Surgery / Valve Surgery ☐ Yes ☐ No Year ____ Pacemaker / Defibrillator ☐ Yes ☐ No Year ____

This past 3 months, have you experienced any of the following symptoms?

Chest Pain / Angina ☐ Yes ☐ No Chest Tightness/Pressure ☐ Yes ☐ No

Shortness of Breath ☐ Yes ☐ No Heart Palpitations / Unusual Cough ☐ Yes ☐ No

Fainting / Dizziness ☐ Yes ☐ No Leg Pain / Arm Pain ☐ Yes ☐ No

Have you been diagnosed with any of the following? (Please circle) HIV or Hepatitis A / B / C

List any other chronic disease you have: ____________________________________

I attest that, to the best of my knowledge, the above information is correct. I read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and the procedure that I am about to undergo. I give permission for the following test(s) to be performed: ______________________________.

____________________ ____________________ ________

Patient Signature *Patient Name* *Date*

WOMEN OF CHILDBEARING AGE – PLEASE FILL OUT THE SECTION BELOW

In order for us to complete the study that has been requested by your physician, we may be required to take x-rays of a certain area of your body. It has been hypothesized that an unborn child in its 1st trimester would be more sensitive to radiation than an adult. In order to ensure that no fetus (unborn child) be exposed to radiation , please complete the following questions below.

Are you pregnant or experiencing a late menstrual period? ☐ Yes ☐ No **Date of last menstrual period** _________

Are you breast feeding? ☐ Yes ☐ No

To the best of my knowledge, I am not pregnant, and I have been informed of the effects of radiation on an unborn child and consent to having the x-rays taken.

____________________ ____________________ ________

Patient Signature *Patient Name* *Date*