



GENERAL INFORMATION FORM

Name: _____ Account/SS #: _____

Date of Birth: _____ Height: _____ Weight: _____

Referring Physician: _____ When will you visit your doctor again? _____

Reason for Exam (check all that apply):

- Reason for Exam options: Cough, Headaches, Mass/lump/nodule, Fever, Wheezing/difficulty breathing, Congestion, Swelling, Pain, Other Symptoms.

Approximately how long have you had this problem? _____

Is this an injury? Yes No If so, date of Injury: _____

Medical History (check all that apply): First Date of Last Menstrual Period: _____

- Medical History options: Diabetes, High Blood Pressure, Smoking, Kidney Disease, Asthma/COPD, Cancer (specify type), Approximate Date of Diagnosis.

Have you had any major surgeries? Yes No

- Major Surgeries options: Heart, Back/Neck, Gall Bladder, Uterus, Appendix.

Other: _____

Prior Studies:

Have you had any previous imaging studies of the body part being examined today? Yes No

Where: _____ When: _____

- Type of exam options: X-Ray, CT, MRI, Ultrasound, Nuclear Medicine, P.E.T.

Have you ever had an allergic reaction to IV contrast used in an imaging procedure (iodine or gadolinium)? Yes No If yes, describe what happened: Are you allergic to latex or barium? Yes No

Patient Signature: _____ Date: _____

Baptist M&S Staff Full Signature: _____ Date: _____