



**GENERAL INFORMATION FORM**

Name: \_\_\_\_\_ Account/SS #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Referring Physicians: \_\_\_\_\_ When will you visit your doctor again? \_\_\_\_\_

**Reason for Exam** (check all that apply):

- Cough
- Headaches
- Mass/lump/nodule
- Fever
- Wheezing/difficulty breathing
- Congestion
- Swelling
- Pain: Location: \_\_\_\_\_ Symptoms are worse:  Right  Left
- 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):

- Diabetes
- High Blood Pressure
- Smoking
- Kidney Disease
- Asthma/COPD
- Cancer (specify type): \_\_\_\_\_ Approximate Date of Diagnosis: \_\_\_\_\_
- Have you had any major surgeries?  Yes  No
- 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:  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: \_\_\_\_\_