RADIOLOGY GROUP OF ABINGTON PATIENT INFORMATION DATA BASE

Patient Name_____

Date of Birth_____ **Social Security Number**_____

Address:_____

_____

Home Telephone:_____ **Cell Phone:**_____

Work Phone:_____ **Other Phone:**_____

E-mail address:_____

Emergency Contact Person and Telephone Number:_____

_____

Referring Physician:_____

Primary Physician:_____

Cardiologist (if applicable):_____

Oncologist (if applicable):_____

Gynocologist (if applicable):_____

Other Physician:_____

Insurance Information:

INSURANCE	
SUBSCRIBER	
ID/GROUP	
PRECERT PHONE NUMBER (***found on back of card)***	

Secondary Insurance (if applicable)

INSURANCE	
SUBSCRIBER	
ID/GROUP	
PRECERT PHONE NUMBER ***(found on back of card)***	

PATIENT INSTRUCTIONS: Complete this section on each page or have someone complete it for you. Check box only if you now have or ever had:

CURRENT/PAST MEDICAL /SURGICAL HISTORY

Reason for visit today:

RESPIRATORY/LUNGS: ☐ ***No Problems***

☐ Asthma	☐ Pneumonia	☐ Tracheotomy
☐ Chronic Bronchitis	☐ Positive TB test	☐ Wheezing
☐ Chronic Cough/ w/ mucus	☐ Recent cold or flu	☐ Shortness of Breath
☐ Emphysema	☐ Sleep Apnea	☐ Cancer_____
☐ Loud Snoring	☐ TB	☐ _____

☐ Smoking history packs/day/years_____ years quit _____

VASCULAR/HEART: ☐ ***No Problems***

☐ Abnormal EKG	☐ Fainting	☐ Irregular heart beat	☐ Swelling of feet/ankles/legs
☐ Blood clots	☐ Heart Attack	☐ Pacemaker	☐ Valve disorder
☐ Chest pain	☐ Heart Blockage	☐ Palpitations	☐ Vein disorder
☐ Chest Pressure	☐ Heart Murmur	☐ Phlebitis	☐ Cancer_____

☐ Circulation problems ☐ High / low blood pressure

☐ Internal Defibrillator ☐ _____

NEUROLOGICAL/BRAIN/SPINAL CORD: ☐ ***No Problems***

☐ Alzheimer's	☐ Balance Problems	☐ Memory problems
☐ Back Pain	☐ Dizziness	☐ Mini Stroke (TIA)
☐ Difficulty Learning	☐ Fainting	☐ Numbness
☐ Difficulty Speaking	☐ Frequent Headaches	☐ Paralysis _____
☐ Seizures	☐ Severe headaches	☐ Slurred Speech
☐ Weakness	☐ Tingling _____	☐ Cancer_____
☐ _____	☐ Stroke	

GASTROINTESTINAL/BOWEL/DIGESTIVE: ☐ ***No Problems***

☐ Bowel Obstruction	☐ Colostomy	☐ Hemorrhoids
☐ Jaundice	☐ Constipation	☐ Hepatitis
☐ Pancreatitis	☐ Chronic diarrhea	☐ Crohn's
☐ Hiatal hernia	☐ Rectal bleeding	☐ Cirrhosis of liver
☐ Excessive burping	☐ Ileostomy	☐ Nausea/Vomiting
☐ Colitis	☐ Heartburn	☐ Irritable bowel
☐ Ulcer	☐ Cancer_____	☐ Alcohol use: drinks/day_____
☐ _____	Weight_____	Height_____

MUSCULOSKELETAL: ☐ ***No Problems***

☐ Arthritis ☐ Fracture ☐ Muscle disease

☐ Pins, Rods, Internal Fixators ☐ Artificial Joints ☐ Gout

☐ Muscle Weakness ☐ Sciatica ☐ Lupus

☐ Osteoporosis ☐ TMJ pain/jaw disorder ☐ Cancer_____

☐ Recent fall or trauma *(when)*_____

☐ _____

ENDOCRINE: ☐ ***No Problems***

☐ Low blood Sugar

☐ Hormone Disorder

☐ Diabetes

☐ Thyroid Disorder

☐ Cancer_____

☐ _____

BLOOD: ☐ ***No Problems***

☐ Anemia ☐ Easy bruising

☐ Blood transfusion

☐ Blood transfusion reaction

☐ Frequent nosebleeds

☐ Immunosuppressed

☐ Cancer_____

☐ _____

PSYCHIATRIC: ☐ ***No Problems***

☐ Anger ☐ Hallucinations ☐ Dementia ☐ Mood swings

☐ Anxiety ☐ Manic Depression (BiPolar) ☐ Depression ☐ Schizophrenia

☐ Eating Disorder ☐ Suicide Attempt

☐ _____

SKIN: ☐ ***No Problems***

☐ Bed sore ☐ Non-healing sore ☐ Shingles ☐ Skin cancer

☐ Skin disorder ☐ Ulcerations ☐ Rashes ☐ _____

URINARY/REPRODUCTIVE: ☐ ***No Problems***

☐ Blood in urine ☐ Kidney stones ☐ Urinary catheter ☐ Burning

☐ Loss of control ☐ Ureterostomy ☐ Pain ☐ Infections

☐ Difficult urination ☐ Frequent urination ☐ Self catheterization

☐ Prostate problems ☐ Sexually transmitted disease

☐ Infertility problems ☐ _____

Females Only:

Last menstrual period_____ Pregnant: ☐ YES ☐ NO ☐ UNSURE

☐ Breast Feeding

EYES/EARS/NOSE/THROAT: ☐ ***No Problems***

☐ Blind	☐ Corneal Implants	☐ Glaucoma	☐ Sinus problems
☐ Deaf	☐ Hearing Aids	☐ TTY needed	☐ Cataracts
☐ Deviated septum	☐ Hearing impairment	☐ Contact lenses	☐ Glasses
☐ Ringing in ears	☐ _____		

OPERATIONS/PROCEDURES: ☐ ***None***
List all surgeries and approximate dates:

Issues with anesthesia***:*** ☐ ***None***

MEDICATIONS/HERBAL SUPPLEMENTS: ☐ ***None***
List medication, dose, and frequency

ALLERGIES: ☐ ***None***
List reactions to allergen

Patient Signature_____ Date_____