



Medical History

Patient Name: _____ DOB: _____ Age: ____ Sex: ____ Weight: _____

Referring Physician: _____ Follow-up appointment: _____

Claustrophobic? Yes ____ No ____ Pregnant? Yes ____ No ____ Allergies: _____

Please describe your chief complaint or symptoms on the area being scanned: _____

Have you had any injuries, trauma, or auto accidents? Yes ____ No ____ Date of injury: _____

Type of injury: _____

Please list all surgeries (locations and dates): _____

Are you a current or previous smoker? Yes ____ No ____ How many years? _____

Have you ever had cancer? Yes ____ No ____ What type? _____

Have you ever had chemotherapy? Yes ____ No ____ When? _____

Have you ever had radiation therapy? Yes ____ No ____ When? _____

Are you diabetic? Yes ____ No ____ What medication do you take for diabetes? _____

Do you have any medical conditions/diseases? Yes ____ No ____ Please explain: _____

Have you had any previous x-rays, MRIs, CTs, etc, related to today's visit (when and where)? _____

How did you hear about Palms Imaging Center? _____

Please give us your feedback by filling out the patient satisfaction survey before leaving the facility.

Thank you for your support!