Scheduling Questionnaire

Appointment Date: _____ Appointment Time: _____

Patient Name: _____ DOB: _____ ☐ M ☐ F

Phone: _____ Referring Physician: _____

Previous Patient: ☐ Yes ☐ No Pregnant: ☐ Yes ☐ No

Insurance: _____ Auth # / Ref #: _____

Scheduled By: _____ Prescription: ☐ Will Fax ☐ With patient

☐ MRI/MRA: _____

☐ CT/CTA: _____

☐ XR/DEXA: _____

CONTRAST	**Y**	**N**	**PACEMAKER**	**Y**	**N**
HIGH B/P	**Y**	**N**	**ANY IMPLANTED ELECTRONIC DEVICE**	**Y**	**N**
DIABETIC	**Y**	**N**	**METAL IN EYES**	**Y**	**N**
OLDER THAN 60	**Y**	**N**	**METAL FROM SURGERY OR INJURY**	**Y**	**N**
KIDNEY DISEASE	**Y**	**N**	**ANEURYSM CLIPS**	**Y**	**N**
KIDNEY REMOVED	**Y**	**N**	**EAR IMPLANT**	**Y**	**N**
ACTIVE GOUT	**Y**	**N**	**LUMBAR SPINE SURGERY**	**Y**	**N**
NEED BLOODWORK	**Y**	**N**	**PREVIOUS CONTRAST REACTION**	**Y**	**N**

PREVIOUS RELATIVE STUDIES: ☐ **Yes** ☐ **No** **WHERE:** _____

ALLERGIES: ☐ **Yes** ☐ **No** **ALLERGIC TO:** _____

COMMENTS: _____

Special Needs or Assistance (describe): _____

DATE	TIME	RESULT*	COMMENTS	INITIALS

***Left message, scheduled, no answer**

Scheduler: _____

Optimal Imaging

St. Vincent's HealthCare

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