



PATIENT INFORMATION FORM

PATIENT INFORMATION												
Last Name:		First Name:		MI:		Exam Date (MM/DD/YYYY):						
Social Security Number (Optional)			Gender		Male Female		Post Menopausal			Yes No		
Height (ft.) (in.)		Weight (lbs.)		Pregnant		Yes No		Hormone Replacement			Yes No	
Birth Date (MM/DD/YYYY):		Age	Self Referred		Yes No		Follow Up?		Yes No		Research Study?	Yes No
CONTACT INFORMATION												
Mailing Address												
City				State	ZIP	E-Mail						
Home Phone		Work Phone			Mobile			Fax				
DEMOGRAPHIC												
Ethnicity		African American	Asian	Caucasian		Hispanic	Other					
Marital Status		Married		Divorced	Single	Widow(er)						
Referring Medium		Doctor	Friend	Radio	TV	Mailer	Sales Rep.	Newspaper	Other			
HABITS												
Do you Diet?		Yes	Low Fat	Low Carbohydrate		High Protein	Other					
Alcohol Intake		Beer	Liquor	White Wine	Red Wine		Amount-Week/Day :					
Caffeinated Beverages (cups/day) : Coffee [] Tea [] Soda []												
REFERRING PHYSICIANS												
Physician #1 Name						Cardiologist?				Yes No		
Phone				Fax								
Street Address												
City				State	ZIP							
EMERGENCY CONTACT												
Name												
Relationship						Spouse		Family	Friends	Other	Emergency Phone	
CHOLESTEROL (values measured in mg/dL)												
LDL		VLDL		HDL		Triglycerides		Total Cholesterol				
On Cholesterol Medication		Yes No		Name:								

SYMPTOMS				OTHER			
Chest Pain (non-cardiac)	Angina			Cancer			
Chest Tightness or Pressure	Leg Pain with Walking			Cancer Type			
Shortness of Breath	Slurring of Speech			Aspirin : No Baby Adult			
Frequent Palpitations	Fainting						
Other symptoms:							
Prior surgeries:							
BLOOD PRESSURE							
High	Years []	Current BP					
SMOKING							
Smoker	Years []	Packs per Day []	Cigars []	Pipes []			
Former Smoker	Quit < 1 Year ago	Quit > 1 year ago					
EXERCISE							
Intensity	None	Low	Medium	High			
Frequency	[] days/week	Duration [] minutes					
DIABETES							
Yes	Years []	Insulin	Oral Drugs	Diet			
MEDICAL HISTORY							
Heart Attack	Stroke	TIA					
Heart Surgery	Bypass	Valve	Coronary	Balloon (PTCA)	Stent		
Vascular Surgery	Carotid	Aorta	Leg				
			Year				
EKG Scan				Normal	Abnormal		
PET Scan				Normal	Abnormal		
Treadmill Test/Nuclear/Stress Echo				Normal	Abnormal		
Angiogram/Cardiac Cath				Normal	Abnormal		
Prior EBT Scan				Normal	Abnormal		
Where?							
FAMILY HISTORY							
Relationship	Cancer	Stroke	Hypertension	Diabetes	Heart Disease Before 55 (65 if female)	Heart Disease After 55 (65 if female)	Abnormal Cholesterol
Parents							
Siblings							
Grand Parents							
RISK FACTORS							
Years Exposed to Second-Hand Smoke	Less than 1 Year	1 – 5 Year	More than 5 Year				
Asbestos Exposure	When []	Other Pollutants:					

Asthma	Chronic Cough	Type:	Dry	Productive
History of Lung Infections		Family Members with Emphysema:		
LIST OF MEDICATIONS				
Medication/Vitamin	Dosage	Frequency		

In an effort to protect your privacy, we have developed a policy on leaving medical care messages, and sending out medical results. We will NOT leave messages with anyone except the patient or legal guardian. We will NOT leave any information on an answering machine / voice mail. We will NOT mail you any of your medical results.

UNLESS

We have your written permission to do so. Please read below and consider carefully whom you want to have access to your medical information.

I, _____ give Accuscan Health Imaging LLC, my permission to leave phone messages regarding my medical care and information listed below. I fully understand that this authorization will remain valid until revoked in writing.

My home / mobile answering machine / voice mail: Phone: (____) _____

My office / work voice mail: Phone: (____) _____

My spouse: Name _____ Phone: (____) _____

Other: _____ Phone: (____) _____

I allow Accuscan Health Imaging to Mail me my final results: Patients Initials

I will personally pick up my results at Accuscan Health Imaging Patients Initials

_____/____/____
 Patient Signature Date

Acknowledgement of Consent

This procedure is considered elective and is not covered by insurance. I understand that Medicare or Medicaid do not cover this procedure.

I understand that I am responsible for all costs of the examination at the time of service.

I give my consent to allow Accuscan Health imaging and its health care providers, agents, contractors, and employees to perform a Computed Tomography (CT) Scan on any part of my body. I understand that any scan performed at Accuscan Health Imaging is not a substitute for regular and routine care by a physician.

I realize there is a small amount of x-ray exposure associated with CT procedures. I further understand that although this screening can help identify certain early disease states, it should not be considered a substitute, or in place of a thorough examinations or testing recommended by a physician. Like all diagnostic tests, a normal scan does not guarantee that I will not have a heart attack or need treatment for coronary disease or any other abnormality.

I understand that CT exams are intended as screening tools and the possibility exists that abnormalities may be found. If such abnormalities are found, I understand that such testing and or diagnostic procedures may be needed to further evaluate the findings. I do understand that such tests and or procedures may entail additional costs for which I am responsible. I understand that Accuscan Health Imaging is not responsible for my follow up medical care. I am responsible for the results of this test and will make them available to my physician.

The body scan procedure is designed to look for abnormalities of the lungs, liver, kidneys, spleen, gallbladder, pancreas, aorta, and abdominal lymph nodes. Cysts, stones, tumors, congenital abnormalities and vascular plaque are among the lesions that can be detected. The procedure does not involve the injection of a contrast dye: therefore many abnormalities may not be detected. Very small tumors, cysts and stones might also not be detected. In addition, a patient consenting for the procedure understands that there may be a higher than usual likelihood for false positives than in other medial diagnostic procedures. In other words, there may be the reporting of lesions of no significance or radiological findings, which are not, in fact, present. On occasion, a patient will be advised to follow up such an abnormal scan with a contrast enhanced CT scan or other procedures that may be recommend by a physician. It is also understood that radiology is not a perfect science and it is quite possible for a radiologist to miss a significant lesion or abnormality by this method. I understand that the body scan is not adequate or not recommended to detect metastasis or to follow-up the progress of someone with a history of cancer. Such patients should only have a body scan if they are interested in a possible opportunity to find some problems, which are unrelated to their cancer diagnosis.

_____ Patient Initials

I have been given an opportunity to ask questions about this procedure and the risks and hazards involved and that I have sufficient information to give this informed consent. I certify that I have read this form and I understand its contents.

Signature

Date

Printed Name

Witness on behalf of Accuscan