INTERVENTIONAL RADIOLOGY CONSULT INTAKE FORM

DR
DESERT RADIOLOGY
a radiology partners practice

Patient Information	
Patient Name:	DOB:
Phone:	Email:
Insurance:	Pharmacy:
Appointment Date:	Appointment Time:

Please indicate if you have any of the following:

	YES	NO			YES	NO
GENERAL				**HEMATOLOGY**		
Fever	☐	☐		*Easy Bruising*	☐	☐
Chills	☐	☐		*Easy Bleeding*	☐	☐
Recent Weight Change	☐	☐		**MUSCULOSKELTAL**		
SKIN				*Muscle Pain*	☐	☐
Rashes	☐	☐		*Joint Pain*	☐	☐
Leg Ulcers / Sores	☐	☐		**NEUROLOGICAL**		
CARDIOVASCULAR				*Decreased Sensation*	☐	☐
Chest Pain	☐	☐		*Seizures*	☐	☐
Heart Palpitations	☐	☐		*Weakness*	☐	☐
Leg pain/ Swelling	☐	☐		**GASTROINTESTIONAL**		
RESPIRATORY				*Abdominal Pain*	☐	☐
Cough	☐	☐		*Nausea*	☐	☐
Shortness of Breath	☐	☐		*Vomiting*	☐	☐
EAR, NOSE, THROAT				*Diarrhea*	☐	☐
Ringing / Noise in Ears	☐	☐		*Constipation*	☐	☐
Decreased Hearing	☐	☐		*Bloody Stools*	☐	☐
Watery Eyes	☐	☐		**EYES**		
Sore Throat	☐	☐		*Vision Change*	☐	☐

☐ **I AM CURRENTLY NOT TAKING ANY MEDICATIONS - PRESCRIPTION, OVER THE COUNTER OR HERBAL.**

If you are currently taking medications, please list them all here and include any over the counter and herbal medicines.

MEDICATION	DOSE	FREQUENCY

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Patient Information	
Patient Name:	DOB:
Referring Provider:	
Consultation for:	
Do you have an advanced directive?	☐ YES ☐ NO ☐ Declined

Health & Medical Information			
Past Medical History:			
Family Medical History:			
Past Surgical History:			
Allergies (list all known):			
Contrast Allergy / Reaction:	☐ YES ☐ NO	If yes, history of premedication:	
Alcohol Use:	☐ YES ☐ NO	If yes, amount per week:	Or per month:
Tobacco Use:	☐ YES ☐ NO	If yes, amount per day:	Number of years:
Exercise:	☐ YES ☐ NO	If yes, amount per week:	Type of exercise:

For Office Use Only			
PT Weight:	PT Height	Blood Pressure:	Temp:
Pulse	SpO2:	Resp:	BMI:
Patient on Blood Thinners:	☐ YES ☐ NO		
Patient is Diabetic:	☐ YES ☐ NO	*If yes*, is patient taking Metformin	☐ YES ☐ NO