IMAGING DEPARTMENT PATIENT ASSESSMENT QUESTIONNAIRE

Name:	Date of Birth:
What can we do to make sure you receive **very good** care?	
Are there any **special needs/considerations** that we should know about?	
Reason you are having this exam:	

Do you have a history of cancer?	☐ Yes	☐ No	If YES, what type? If YES, what part of body?
Radiation Therapy?	☐ Yes	☐ No	
Chemotherapy?	☐ Yes	☐ No	

List any imaging exams you have had in the past year:		
Exam Type:	Where:	When:
Exam Type:	Where:	When:
Exam Type:	Where:	When:
Exam Type:	Where:	When:
Exam Type:	Where:	When:

FALL RISK ASSESSMENT		
☐ Yes	☐ No	Do you feel unsteady when you walk?
☐ Yes	☐ No	Do you need assistance walking?
☐ Yes	☐ No	In the past year, have you had any falls or near falls?
☐ Yes	☐ No	Are you taking any of the following medications: anticonvulsants, depression, anxiety or sleeping medications?
☐ Yes	☐ No	Have you experienced any agitation, confusion, disorientation or forgetfulness?

PREGNANCY SCREENING (FEMALE PATIENTS ONLY)		
It is the policy at North Central Surgical Center to prevent accidental irradiation of an unrecognized pregnancy. We require the following information for female patients between the ages of 11 and 60 years old. If the information below indicates even a remote possibility of pregnancy, you will be required to have a pregnancy test prior to any exam involving radiation or magnetic resonance imaging (MRI).		
☐ Yes	☐ No	Have you had a hysterectomy?
☐ Yes	☐ No	Have you gone through menopause?
☐ Yes	☐ No	Do you have any reason to believe that you might be pregnant? If yes, please notify your technologist immediately.

I have read and understood the above information and the information above is correct.			
Printed Name Patient/Legal Representative	Signature Patient/Legal Representative	Date	Time