PLEASE PRINT CLEARLY

Hackensack Meridian *Health*

Date: ____/____/_____
Time: _____:_____

Patient Name: _____ Date of Birth: ____/____/_____
Last First MI

Sex: ○ Male ○ Female Height: _____ Weight:_____ Race:_____
Address: _____ City: _____ Zip: _____
Phone: (____) _____-_____ Social Security: _____-_____-_____
Preferred Language*: _____ E-Mail*: _____

Medical History

☐ **I have reviewed this form and acknowledge there are no changes to my medical history since my last exam**

List any medications you are currently taking:

List any allergies that you have:

Are you experiencing any pain? ○ Yes ○ No Where? _____ Rate from 1-10 (1 is lowest) _____
Do you smoke? ○ Yes ○ No If yes, how much? _____
Do you have any previous related studies? ○ Yes ○ No Specify Type of Exam: _____
Facility: _____
Are you pregnant? ○ Yes ○ No First day of menstrual period: ___/___/_____ Date of menopause: ___/___/_____
Do you have any of the following? ○ Cancer (Where: _____) ○ Tumor/Lump/Mass (Where: _____)
○ Seizures ○ Stroke ○ Diabetes ○ Asthma ○ Crohn's ○ Kidney Disease
○ Renal Failure ○ Spinal Surgery ○ Other Illness/Disease: _____
Have you ever had a reaction to: ○ Novocaine ○ Lidocaine ○ LATEX
Previous ○ Chemotherapy or ○ Radiation? ○ Yes ○ No When? ____/____/_____

Do you have a NEULASTA ON-BODY INJECTOR/PUMP?
○ Yes (You cannot have the exam until the pump is removed by your physician) ○ No
Do you have a FREESTYLE LIBRE FLASH GLUCOSE MONITORING SYSTEM or a DEXCOM G6 GLUCOSE MONITORING SYSTEM? ○ Yes (The sensor must be removed before you can have the exam) ○ No

***JFK Advanced Medical Imaging is complying with the Health Information Technology for Economic and Clinical Health Act of 2009 which is part of the American Recovery and Reinvestment Act (ARRA) of 2009. Medical facilities are now required to collect health related information as part of healthcare reform. This is designed to improve the health of our patients and the quality, safety, and efficiency of healthcare systems.**

Ultrasound/Sonogram

Reason for Exam: _____
Any menstrual abnormalities (Please List):_____
Length of period (days):_____ Days between periods: _____
Number of: Pregnancies:_____ Children:_____ Miscarriages:_____ Abortion:_____

Have you ever (Answer "Yes" or "No" then answer appropriately):

○ Yes ○ No Had a Caesarean delivery? Number: _____
○ Yes ○ No Had complications in a previous pregnancy? What? _____
○ Yes ○ No Had a stillborn or child with a congenital abnormality? What? _____
○ Yes ○ No Used an IUD? How long? _____

MRI, CT, and PET/CT

Reason for Exam: _____

Please answer ALL of the following questions so we can make certain it is safe for you to undergo an MRI:

1) Do you have a PACEMAKER, COCHLEAR IMPLANT, IMPLANTED HEART VALVES, NEUROSTIMULATOR BREAST EXPANDER, or have you had any brain surgery requiring ANEURYSM CLIPS? If you answer "YES", please see the registrar immediately ○ Yes ○ No
2) Have you ever been exposed to, or treated for metal fragments that could be lodged in your eyes or body? ○ Yes ○ No
3) Do you wear a hearing aid, insulin pump, dentures, medication patch, or any other removable object? ○ Yes ○ No
4) Do you wear a Nicotine or Medication patch? ○ Yes ○ No
5) Are you claustrophobic or do you have a fear of enclosed and narrow spaces? ○ Yes ○ No
6) Are you breast feeding? ○ Yes ○ No
7) Can you lie flat and still? ○ Yes ○ No

Please check if you have had any of the following surgery:

○ Hysterectomy ○ Gall Bladder ○ Colon ○ Heart ○ Lung ○ Breast ○ Appendectomy ○ Neck ○ Sinuses
○ Prostate ○ Kidney ○ Spleen ○ Back/Spine ○ Other (Please Specify): _____

Have you had a previous bone marrow shot? ○ Yes ○ No When? ____/____/_____

DEXA/Bone Density

Reason for Exam: _____

Please answer ALL of the following questions:

1) Have you had a previous hip or vertebral fracture? ○ Yes ○ No
2) Have you had any fractures during your adult life which did not result from significant trauma? ○ Yes ○ No
3) Did either of your parents ever have a hip fracture? ○ Yes ○ No
4) Do you smoke? ○ Yes ○ No
5) Have you ever taken Glucocorticoids? ○ Yes ○ No
6) Do you have rheumatoid arthritis? ○ Yes ○ No
7) Do you have secondary osteoporosis? ○ Yes ○ No
8) Do you drink 3 or more alcoholic drinks per day? ○ Yes ○ No
9) Are you being treated for osteoporosis? ○ Yes ○ No
10) Have you ever taken any of the following medications?
☐ Actonel / risedronate ☐ Evista / raloxifene ☐ Fosamax / alendronate ☐ Miacalcin / calcitonin ☐ Vitamin D
☐ Reclast / zoledronate ☐ Boniva / ibandronate ☐ Forteo / parathyroid hormone ☐ Prolia / denosumab ☐ Multivitamin
☐ HRT (i.e. estrogen/hormone therapy) ☐ Protelos / strontium ranelate ☐ Calcium ☐ Other: _____
11) Do you have any of the following conditions? ☐ Anorexia / Bulimia ☐ End stage renal disease ☐ Hysterectomy
☐ Hyperparathyroidism ☐ Inflammatory bowel diseases ☐ Other (Please Specify): _____
12) What was your maximum height? _____
13) Do you perform weight bearing exercise regularly? ○ Yes ○ No
14) Do you regularly consume dairy products? ○ Yes ○ No
15) Do you drink caffeinated beverages? ○ Yes ○ No
16) Age of first period _____
17) How many full term pregnancies have you had? _____
18) Have you ever missed your period for more than 6 months in a row (not including pregnancy or menopause)? ○ Yes ○ No

Signature: _____ Date: ____/____/_____
Technologist Signature: _____ Date: ____/____/_____