TORRANCE MEMORIAL
A CEDARS-SINAI AFFILIATE

Imaging Services

Outpatient History This section staff use only

Verify patient ID (two required)	Date: ____/____/___ Time: _____	Age of the patient Age: _____	Actual height and weight Height: ____Weight: ____ ☐ N/A	Pregnant ☐ Yes ☐ No	Breastfeeding ☐ Yes ☐ No
☐ Name ☐ DOB ☐ Other					

Patient/family to complete the following:

Language spoken: _____

1. Health problems: check and/or circle if you have or had any of the following:

	Yes		Yes		Yes		Yes
Diabetes		High/low blood pressure		Difficulty swallowing		Depression/anxiety	
Cancer _____(type)		Pacemaker/AICD		Seizures		COPD/pneumonia	
Asthma/trouble breathing		Surgical clips/staples		Difficulty urinating		Unsteady walk/falls	
Thyroid problems		Hepatitis/liver disease		Arthritis		Chest pain	
Kidney disease/surgery		Heart problems/disease		Stroke/TIA		Headache/dizziness	
Dialysis		Chemotherapy		Claustrophobia		Migraine	

2. Pain: ☐ No ☐ Yes Circle number that describes the intensity of your pain: (1 – 3 mild, 4 – 7 moderate, 8 – 10 severe) 1 2 3 4 5 6 7 8 9 10
Type/quality: _____ Location: _____ Patient stated pain goal (age appropriate scale 0 – 10): _____

3. Previous surgeries: _____

4. Medications: List all prescription and over-the-counter medications, herbal remedies and/or supplements.

Name of medication (PLEASE PRINT CLEARLY)	Dose	How it's taken	How often	Time of last dose	Name of medication (PLEASE PRINT CLEARLY)	Dose	How it's taken	How often	Time of last dose

5. Medication allergies: Have you had a true allergic reaction – such as: 1. Red rash 2. Hives 3. Swelling 4. Shortness of breath 5. Wheezing – to any drugs? ☐ No ☐ Yes
If yes, state name of medication, and indicate type of reaction to each: _____

6. Medication side effects: Have you had a significant side effect – such as: 1. Vomiting 2. Upset stomach 3. Diarrhea 4. Constipation 5. Headache – to any drugs? ☐ No ☐ Yes
If yes, state name of medication, and indicate type of reaction to each: _____

7. Allergies: Have you had an allergic reaction to food or other substances? ☐ No ☐ Yes If yes, list item and reaction: _____

8. Latex allergy: When exposed to latex or rubber, (including rubber gloves used by you or your doctor, balloons, condoms) do you suffer runny nose, watery eyes, wheezing or rash?
☐ No ☐ Yes Explain: _____
Do you have spina bifida or repeated catheterizations from congenital defects? ☐ No ☐ Yes Explain: _____
Do you have breathing reactions (wheezing, shortness of breath) to tropical or pitted fruits (e.g., bananas, kiwis, chestnuts, avocados or cherries)? ☐ No ☐ Yes
Explain: _____

THIS SECTION FOR STAFF USE: IF YES HAS BEEN CHECKED OFF ONE OR MORE TIMES, USE LATEX PRECAUTIONS
☐ Latex precautions indicated and initiated ☐ Latex allergy education material provided to patient
Preferred method of learning: ☐ Visual ☐ Auditory ☐ Written
Barriers to learning: No cultural, religious practice, language or emotional barriers. No physical or cognitive limitations. If yes, identify: _____

☐ **No evidence of abuse or neglect. If evidence of abuse/neglect, social services notified.**
☐ **No special cultural needs identified** (i.e., religious or dietary practices). If yes, identify: _____
Patient or significant other verbalizes understanding of education/instructions. If no, provide plan for reeducation in progress notes. ☐ See notes.
Reviewed by _____ **Signature/title** ☐ **Faxed to pharmacy**

OUTPATIENT HISTORY AND DOCUMENTATION IMAGING

PATIENT IDENTIFICATION