

Patient/family to complete the following: .anguage spoken:	Verify patient ID (two required)  Name DOB Other	) Da	e only ate:/_ me:			f the pati			ght and weig _Weight:		Pregn /A Ye	ant s  No	Breastfe	
Health problems: check and/or circle if you have or had any of the following:    Yes	Patient/family to complete		lowing:		-									
Difficulty swallowing   Depression/anxiety   Depr		r circle if	uou have or	had anu	of the follo	owina:								
Diabetes	Treatin problems, one on ana you	т т	god nave o	noo ong	01 (110 10()					Yes				Yes
Cencer(type)	——————————————————————————————————————		High/low bl	nod press	e		Diffic	ultu swallowir	าก		Denressin	n/anxietu		
Ashma/trouble breathing   Surgical clips/staples   Difficulty urinating   Unsteady walk/falls		<del>                                     </del>							-5		<u> </u>			
Arthrills Chest pain  Gidney disease/surgory Heart problems/disease Stroke/TIA Headache/disziness  Claustrophobia Migraine  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  Pedient stated pain goal (age appropriate scale 0 - 10):  Previous surgeries:    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 off last (PLEASE PRINT CLEARLY)   Dose   How It's taken   How off last (PLEASE PRINT CLEARLY)   Dose   How It's taken   How off last (PLEASE PRINT CLEARLY)   Dose   How It's taken   How off last (PLEASE PRINT CLEARLY)   Dose   How It's taken   How It														
Heart problems/disease   Stroke/TIA   Headache/dizziness   Dialysis   Chemotherapy   Claustrophobia   Migraine														
Dalysis   Chemotherapy   Claustrophobia   Migraine    Pain:	3 .		<u>'</u>			+ +								
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  pe/quality:					300									
Name of medication (PLEASE PRINT CLEARLY)  Dose    How it's taken   How often of last dose   Name of medication (PLEASE PRINT CLEARLY)   Dose it sken   How it's taken   How often of last dose   PLEASE PRINT CLEARLY)   Dose it sken   How it's often of dote	pe/quality: Location	on:		Patie	nt stated p	oain goal (	age ap	propriate scal	erate, 8 – 10 se le 0 – 10):	evere) 1	2 3 4 5	6 7 8	9 10	
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?  \  \text{No } \  \text{Yes}, state name of medication, and indicate type of reaction to each: \  \  \  \  \  \  \  \  \  \  \  \  \	Name of medication			How	How	Time	ies and	Name o	of medication	VI	Dose	1		Time of las
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 yes, state name of medication, and indicate type of reaction to each:  Altergies: Have you had an altergic reaction to food or other substances?  No Yes If yes, list item and reaction:  Latex altergy: When exposed to latex or rubber, (including rubber gloves used by you or your doctor, balloons, condoms) do you suffer runny nose, watery enterging or rash?  No Yes Explain:  Joyou have spina bifida or repeated catheterizations from congenital defects?  No Yes Explain:  Joyou have breathing reactions (wheezing, shortness of breath) to tropical or pitted fruits (e.g., bananas, kiwis, chestnuts, avocados or cherries)?  No Yes explain:  Joyou have breathing reactions (wheezing, shortness of breath) to tropical or pitted fruits (e.g., bananas, kiwis, chestnuts, avocados or cherries)?  No Yes explain:  Joyou have breathing reactions (wheezing, shortness of breath) to tropical or pitted fruits (e.g., bananas, kiwis, chestnuts, avocados or cherries)?  No Yes explain:  Joyou have breathing reactions (wheezing, shortness of breath) to tropical or pitted fruits (e.g., bananas, kiwis, chestnuts, avocados or cherries)?  No Yes explain:  Joyou have breathing reactions (wheezing, shortness of breath) to tropical or pitted fruits (e.g., bananas, kiwis, chestnuts, avocados or cherries)?  No Yes explain:  Joyou have breathing reactions (wheezing, shortness of breath) to tropical or pitted fruits (e.g., bananas, kiwis, chestnuts, avocados or cherries)?  No Yes explain:  Joyou have breathing reactions (wheezing, shortness of breath) to tropical or pitted fruits (e.g., bananas, kiwis, chestnuts, avocados or cherries)?  No Yes explain:  Joyou have breathing reactions (wheezing, shortness of breath) to tropical or pitted fruits (e.g., bananas, kiwis, chestnuts, avocados or cherries)?  No Yes explain:  Joyou have breathing reactions (wheezing, shortness of breath) to trop				taken		dose						taken		dose
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**OUTPATIENT HISTORY AND DOCUMENTATION IMAGING** 

PATIENT IDENTIFICATION