



# NEXT GENERATION RADIOLOGY

GREAT NECK  
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516-248-3210

www.nextgenerationrad.com

Name	Date (mm/dd/yyyy)	Age (years)
first                      middle initial                      last		
Account #	Unit Number	Referring Doctor

Procedure/Test	Creatinine (current/baseline)
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**DO YOU HAVE ANY HISTORY OF ALLERGIES (foods or medications) OR ASTHMA?** CIRCLE ALL THAT APPLY

V07.1 Desensitization to allergens	V14.0 Penicillin	V14.1 Other Antibiotic Agents	V14.2 Sulfonamides
V14.8 Previous adverse reaction to contrast. When?	V14.3 Other anti-infective	V14.4 Anesthetic Agents	V14.5 Narcotic Agents
Describe:	V14.7 Serum or Vaccines	V14.8 Other Medications	V14.9 Unspecified Meds
	493.90 History of Asthma	495.9 Unspecified Allergic	995.3 Non-specified Allergy
	995.2 Adverse Drug Effect, Medicinal or Biological		Other:
V14.6 Analgesic Agents	995.1 Angioneurotic Edema	995.0 Anaphylactic Shock	
V15.0 Allergy to Non Medications			

Additional Comments:

**DO YOU HAVE ANY HISTORY OF HEART CONDITIONS?** CIRCLE ALL THAT APPLY

416.0 Pulmonary Hypertension	402.90 Hypertension	411.1 Intermediate Coronary Syndrome (Angina)	427.41 Ventricular Fibrillation
428.0 Congestive Heart Failure	427.31 Atrial Fibrillation	429.2 Cardiovascular Disease, Unspecified	Other:
427.9 Arrhythmias	427.60 Premature Beats, Unspecified		
429.9 Heart Disease, Unspecified			

Additional Comments:

**DO YOU HAVE ANY HISTORY OF CHRONIC OR DEBILITATING CONDITIONS?** CIRCLE ALL THAT APPLY

203.00 Multiple Myeloma without Mention of Remission	203.01 Multiple Myeloma in Remission	250.00 Diabetes Mellitus without Mention of Complication	282.61 Hb-S without Mention of Crisis
282.60 Sickle Cell Anemia	518.81 Respiratory Failure	250.93 Diabetes Mellitus with Ketoacidosis	V42.0 Renal Transplant
799.3 Unspecified Debilitation	282.63 Sickle Cell/Hb-S	V46.1 Dependence on respirator	Other:
Describe:	586 Renal Failure, unspecified	799.4 Wasting (cachexia)	
	585 Renal Failure, chronic		

Additional Comments:

**OTHER HISTORY**

If you are currently taking prescription medications, what for? \_\_\_\_\_

If you are taking blood thinners, what kind (including aspirin)? \_\_\_\_\_ What dosage? \_\_\_\_\_

If you have ever been diagnosed with cancer, please describe: \_\_\_\_\_

Describe any radiation or chemotherapy: \_\_\_\_\_ Last Treatment (mm/dd/yyyy) \_\_\_\_\_

Female Patients: Is there any possibility that you may be pregnant? \_\_\_\_\_ Last Menstrual Period (mm/dd/yyyy) \_\_\_\_\_

**Why** did your doctor request this test? \_\_\_\_\_

What previous diagnostic tests have you had for the same area that you are having examined today: CIRCLE ALL THAT APPLY

MRI    CAT Scan    Nuclear Medicine    X-Rays/Fluoroscopy/DEXA    Ultrasound    Mammogram    Blood Work/Biopsy

Please describe findings: \_\_\_\_\_

Please describe previous surgery in the area that you are having examined today (include dates): \_\_\_\_\_

**Explanation about the nature of the procedure has been discussed with me. I have had all of my questions regarding this procedure answered.**

PATIENT/GUARDIAN SIGNATURE	DATE
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### OFFICE USE ONLY

Pre-medication Given?    Y    N    Medications and dosage: \_\_\_\_\_

Type/Amount of contrast administered: \_\_\_\_\_ IV Location: \_\_\_\_\_

Signature of Technologist: \_\_\_\_\_ Radiologist Signature: \_\_\_\_\_