



NEXT GENERATION RADIOLOGY

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PORT JEFFERSON STATION
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631-928-1600

GARDEN CITY PARK
2403 Jericho Tpke.
516-248-3210

www.nextgenerationrad.com

Name _____ Today's Date (mm/dd/yyyy) _____
first middle initial last

What test(s) are you here for? _____ Have you recently had similar tests elsewhere? Y N

Why did your doctor(s) say they were requesting this? _____

What are your symptoms, briefly? _____

What other medical problems do you have? _____

What prior surgeries have you had and when? _____

What allergies do you have (include medications and foods)? _____

Are you a diabetic? Y N If so, are you on Glucophage (Metformin) or Glucovance? Y N

Do you have renal failure or kidney disease? _____

Do you have a Pacemaker or other metal in your body? _____

Do you have a history of smoking? Y N If so, for how many total years? _____

Are you currently smoking? Y N

If you are a former smoker, how many years ago did you last smoke? _____

Female Patients: Is there any possibility that you may be **pregnant**? _____

Other than the ordering doctor, please list the full name and fax number of other doctors who should receive the final report of today's test(s):
