



Test Scheduling Questionnaire

Today's Date: _____

Patient Name: _____ DOB: _____

SSN: _____ Home Phone: _____ Work: _____

Cell: _____

Please answer the following:

Have you had a dexascan in the last 2 years? Y__ N__ What year? _____

Are you claustrophobic? Y__ N__

Are you diabetic? Y__ N__

Are you taking glucophage? Y__ N__

Are you over 300 pounds? Y__ N__

Are you taking any blood thinners? Y__ N__

Do you have asthma? Y__ N__

List your previous surgeries: _____

Do you have a pacemaker? Y__ N__

Do you have any metal in your body? Y__ N__ If yes, where? _____

Have you been diagnosed with cancer? Y__ N__

List your allergies: _____

Family Doctor: _____

Please check name of surgeon below:

____ Dr. Richard Hynes

____ Dr. Devin Datta

____ Dr. Mitchell Supler