HDI
High Desert Imaging

**PLEASE ANSWER ALL QUESTIONS**

**DATE:** | **WEIGHT:** **HEIGHT:**

NAME: DOB: SEX M / F

PLEASE DESCRIBE SYMPTOMS: (Pain, numbness, headache etc.)

WERE YOU INJURED IN THE AREA BEING EXAMINED? YES / NO

**IF YES**, HOW WERE YOU INJURED: (Fall, Accident, Lifting etc)

HAVE YOU HAD SURGERY IN THE AREA BEING EXAMINED? YES / NO

**IF YES**, WHEN (Approximate Year)

HAVE YOU EVER HAD CANCER? YES / NO

**IF YES**, WHAT TYPE:

DO YOU HAVE ANY BLOOD DISORDERS, RENAL DISEASE, OR SEIZURES? YES / NO

**IF YES**, DESCRIBE:

HAVE YOU EVER HAD A CT? YES / NO

**IF YES**, ON WHAT BODY PART:

DO YOU HAVE ANY DRUG ALLERGIES? YES / NO

**IF YES**, PLEASE LIST:

DO YOU SMOKE? YES / NO

ARE YOU DIABETIC? YES / NO

ARE YOU PREGNANT OR EXPERIENCING A LATE PERIOD? YES / NO

ARE YOU BREAST FEEDING? YES / NO

Please list all studies you may have had recently that might pertain to the body part being examined today
(X-Rays, MRI's, Cat Scans, etc)