Vantage RADIOLOGY INTERVENTIONAL SERVICES

PATIENT QUESTIONNAIRE

In order to best serve your medical needs, we ask that you complete the following questionnaire as accurately as possible. The healthcare provider-patient relationship is one built upon trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false information may seriously and adversely affect your health and our ability to provide you with the highest quality medical care.

PATIENT NAME: _____ GENDER: ☐ M ☐ F

REFERRING PROVIDER: _____ DATE OF BIRTH (MM / DD / YYYY): _____

PATIENT ADDRESS: _____

_____ SS#: _____

HOME PH.: _____ WORK PH.: _____ MOBILE: _____

NOTE: We will need a copy of the patient's photo ID.

If the person completing this form is not the patient, please write in the space below, your name, your relationship to the patient, and the reason the patient is unable to complete the form.

NAME: _____

RELATIONSHIP TO PATIENT: _____

REASON: _____

INSURANCE INFORMATION

COMPANY: _____

SUBSCRIBER NAME: _____

POLICY # AND GROUP: _____

ADDRESS: _____

_____

ADDITIONAL/SECONDARY INSURANCE INFORMATION

COMPANY: _____

SUBSCRIBER NAME: _____

POLICY # AND GROUP: _____

ADDRESS: _____

_____

EMERGENCY CONTACT

NAME: _____

RELATIONSHIP TO PATIENT: _____

HOME PH.: _____

WORK PH: _____

MOBILE: _____

Please list the names and phone numbers of the Healthcare Providers from whom you are currently receiving care, or from whom you have received prescriptions.

NAME: _____

PHONE: _____

NAME: _____

PHONE: _____

NAME: _____

PHONE: _____

NAME: _____

PHONE: _____

MEDICARE PATIENTS

If you are currently a patient in a skilled nursing facility, please list the name of the facility here: _____

Address: _____ Phone: _____

IMPORTANT

I understand that regardless of insurance or third party coverage, I am responsible for the payment of these services provided by Vantage Interventional Services. I further understand that it is my responsibility to verify my insurance benefits, and, insofar as my insurance company is contracted with Vantage Interventional Services, I am responsible for any unpaid balances. I authorize Vantage Interventional Services to release to my insurance company any information requested in order to expedite payment of this claim. I authorize payments of benefits to Vantage Interventional Services. I authorize release of all my x-rays and radiology reports to the provider handling my healthcare.

Signed: _____ Date: _____

*By signing below, I attest that I have been offered a copy of the Vantage Interventional Services Patient Privacy Statement

Signed: _____ Date: _____

Please list all of the medications that you are currently taking. Include any over the counter medications, herbs, and vitamins. Please also list the name of the prescribing provider.

MEDICATION	DOSE	PRESCRIBED BY	MEDICATION	DOSE	PRESCRIBED BY

Please list and describe any allergies and associated reactions you have had to medications, food, or insect stings.

Check if you are allergic to: ☐ Shellfish ☐ IV Contrast Dye ☐ Local Anesthetic ☐ Penicillin

ALLERGY	REACTION

SURGICAL HISTORY

SURGERY OR PROCEDURE	DATE	NAME OF PROVIDER

Family Medical History: Please list any major health issues concerning members of your family, and indicate which family member.

M = Mother F = Father B = Brother S = Sister D = Daughter So = Son GM = Grandmother GF = Grandfather (m-maternal / p-paternal)

MEDICAL PROBLEM	FAMILY MEMBER(S) AFFECTED									
	M	F	B	S	D	So	m-GM	m-GF	p-GM	p-GF
	M	F	B	S	D	So	m-GM	m-GF	p-GM	p-GF
	M	F	B	S	D	So	m-GM	m-GF	p-GM	p-GF
	M	F	B	S	D	So	m-GM	m-GF	p-GM	p-GF
	M	F	B	S	D	So	m-GM	m-GF	p-GM	p-GF

Additional information you feel may be helpful for your healthcare provider to know:

Healthcare Provider Notes:

PATIENT PAST MEDICAL HISTORY (Please check all that apply):

Adrenal Dysfunction	☐ Yes	☐ No
Alzheimer	☐ Yes	☐ No
Amyotrophic Lateral Sclerosis	☐ Yes	☐ No
Anorexia or Bulimia	☐ Yes	☐ No
Anxiety Disorder	☐ Yes	☐ No
Arterovenous Malformations	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Autoimmune Disease	☐ Yes	☐ No
Bipolar Disorder	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Cerebrovascular Accident (Stroke)	☐ Yes	☐ No
Chemotherapy (if yes, state when)	☐ Yes	☐ No
Claudication	☐ Yes	☐ No
Clotting Disorder	☐ Yes	☐ No
Congenital Heart Defects	☐ Yes	☐ No
Coronary Artery Disease	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No
Eclampsia or Pre-eclampsia	☐ Yes	☐ No
Endocarditis	☐ Yes	☐ No
Endometriosis	☐ Yes	☐ No
End Stage Renal Disease	☐ Yes	☐ No
Erectile Dysfunction	☐ Yes	☐ No
Esophageal Dysfunction	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No
Gallstones	☐ Yes	☐ No
Gastritis or Gastric Ulcers	☐ Yes	☐ No
GERD (acid-reflux)	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Heart or Valve Defects	☐ Yes	☐ No
Hemochromatosis	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
HIV or AIDS	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Hyperthyroidism	☐ Yes	☐ No
Hypotension	☐ Yes	☐ No
Hypothyroidism	☐ Yes	☐ No
Inflammatory Bowel Disease	☐ Yes	☐ No
Irregular Heart Rhythm	☐ Yes	☐ No
Kyphosis	☐ Yes	☐ No
Liver Dysfunction	☐ Yes	☐ No
Kidney Failure	☐ Yes	☐ No
Kidney Dysfunction	☐ Yes	☐ No
Malignancy (if yes, describe below)	☐ Yes	☐ No
_____		
Mania	☐ Yes	☐ No
Muscular Dystrophy	☐ Yes	☐ No
Myocardial Infarction (Heart Attack)	☐ Yes	☐ No
Narcolepsy	☐ Yes	☐ No
Obstructive Sleep Apnea	☐ Yes	☐ No
Organ Transplant (if yes, describe below)	☐ Yes	☐ No
_____		
Osteoporosis	☐ Yes	☐ No
Pancreatitis	☐ Yes	☐ No
Periodic Limb Movement Disorder	☐ Yes	☐ No
Peripheral Artery Disease	☐ Yes	☐ No
Personality Disorder	☐ Yes	☐ No
Pituitary Dysfunction	☐ Yes	☐ No
Polycystic Ovarian Syndrome	☐ Yes	☐ No
Pulmonary Artery Hypertension	☐ Yes	☐ No
Pulmonary Fibrosis	☐ Yes	☐ No
Radiation Therapy (if yes, explain)	☐ Yes	☐ No
_____		
Recurrent Infections	☐ Yes	☐ No
Restless Leg Syndrome	☐ Yes	☐ No
Sarcoidosis	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No
Scleroderma	☐ Yes	☐ No
Scoliosis	☐ Yes	☐ No
Seizure Disorder	☐ Yes	☐ No
Sickle Cell	☐ Yes	☐ No
Sjogren	☐ Yes	☐ No
Skin Disorders (Psoriasis, Acne, etc.)	☐ Yes	☐ No
Thalassemia	☐ Yes	☐ No
Thrombocytopenia	☐ Yes	☐ No
Thrombophilia	☐ Yes	☐ No
Transfusions	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
-If Yes, have you been treated?	☐ Yes	☐ No
Urinary Retention or Urgency	☐ Yes	☐ No
Vasculitis	☐ Yes	☐ No
Visual Defects	☐ Yes	☐ No
Vocal Cord Dysfunction/Paralysis	☐ Yes	☐ No

REVIEW OF SYMPTOMS (In the last 6 months, have you experienced any of the following symptoms? Respond to each.):

CONSTITUTIONAL:

Weight loss or gain	☐ Yes	☐ No
Appetite changes	☐ Yes	☐ No
Fatigue, impairing function	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Shakes/sweats from withdrawal	☐ Yes	☐ No

EYES:

Eye pain or drainage	☐ Yes	☐ No
Visual changes	☐ Yes	☐ No
Dry, Irritated eyes	☐ Yes	☐ No

ENT/MOUTH:

Ear pain or drainage	☐ Yes	☐ No
Frequent sinus infections	☐ Yes	☐ No
Hearing changes or loss	☐ Yes	☐ No
Nosebleeds	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No

RESPIRATORY:

Blood in your sputum	☐ Yes	☐ No
Chest tightness	☐ Yes	☐ No
Cough lasting >1 month	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Chest pain with inhalation/coughing	☐ Yes	☐ No

CARDIOVASCULAR:

Chest pain or heaviness	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Fainting or near-fainting spells	☐ Yes	☐ No
Swelling of legs or feet	☐ Yes	☐ No
Shortness of breath while lying flat	☐ Yes	☐ No

GASTROINTESTINAL:

Abdominal pain	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea or food intolerance	☐ Yes	☐ No
Heartburn or indigestion	☐ Yes	☐ No
Vomiting or nausea lasting >1 day	☐ Yes	☐ No
Swallowing difficulty	☐ Yes	☐ No

PSYCH:

Anxiety without clear explanation	☐ Yes	☐ No
Sadness lasting for days/weeks	☐ Yes	☐ No
Hearing voices	☐ Yes	☐ No
Thoughts of harming yourself	☐ Yes	☐ No
Thoughts of harming others	☐ Yes	☐ No
Fear of people, places, or things	☐ Yes	☐ No

GENITOURINARY:

Blood in urine	☐ Yes	☐ No
Menstrual changes	☐ Yes	☐ No
Painful/difficult urination	☐ Yes	☐ No
Erection problems	☐ Yes	☐ No
Vaginal discharge or bleeding	☐ Yes	☐ No

MUSCULOSKELETAL:

Broken bones	☐ Yes	☐ No
Joint pain or swelling	☐ Yes	☐ No
Muscle aches	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No
Back pain	☐ Yes	☐ No

SKIN / BREAST:

Masses or lumps	☐ Yes	☐ No
Nipple discharge	☐ Yes	☐ No
Rashes or non-healing ulcers	☐ Yes	☐ No

NEUROLOGIC:

Seizures	☐ Yes	☐ No
Coughing/choking with swallowing	☐ Yes	☐ No
Excessive daytime sleepiness	☐ Yes	☐ No
Extremity pain/burning sensations	☐ Yes	☐ No
Hallucinations	☐ Yes	☐ No
Numbness or tingling	☐ Yes	☐ No
Difficulty falling/staying asleep	☐ Yes	☐ No

ENDOCRINOLOGIC:

Hair loss	☐ Yes	☐ No
Frequent urination	☐ Yes	☐ No
Increased thirst	☐ Yes	☐ No
Heat or cold intolerance	☐ Yes	☐ No

HEME/LYMPH:

Bleeding from gums/nose	☐ Yes	☐ No
Unexplained bruising	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Swollen, painful lymph nodes	☐ Yes	☐ No

ALLERGY/IMMUNE:

Watery eyes	☐ Yes	☐ No
Runny nose	☐ Yes	☐ No
Food intolerance	☐ Yes	☐ No
Frequent skin sores	☐ Yes	☐ No

Vantage RADIOLOGY INTERVENTIONAL SERVICES

A professional service corporation, formerly Valley Radiologists, Inc., P.S.