Vantage In RADIOLOGY	order to best serve your me ossible. The healthcare provi is form, you acknowledge th	UESTIONNAIRE edical needs, we ask that you complete the following questionnaire as accurated der-patient relationship is one built upon trust and honesty. By completing and hat you understand that any intentionally false information may seriously and a ility to provide you with the highest quality medical care.
PATIENT NAME:		GENDER: M F
		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.		EMERGENCY CONTACT
If the person completing this form is not the patient, space below, your name, your relationship to the patient is unable to complete the form. NAME:	tient, and the reason	NAME:
RELATIONSHIP TO PATIENT: REASON:		WORK PH:
INSURANCE INFORMATION		
COMPANY:		Please list the names and phone numbers of the Healthcare Provider: from whom you are currently receiving care, or from whom you have received prescriptions.
POLICY # AND GROUP:		NAME:
ADDRESS:		PHONE:
ADDITIONAL/SECONDARY INSURANCE		NAME:
		PHONE:
		NAME:
SUBSCRIBER NAME: POLICY # AND GROUP:		PHONE:
ADDRESS:		NAME:

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

Address:

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:

PHONE:

Phone:

*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.

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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	REACT	ION				

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	FAM	FAMILY MEMBER(S) AFFECTED									
	М	F	В	S	D	So	m-GM	m-GF	p-GM	p-GF	
	М	F	В	S	D	So	m-GM	m-GF	p-GM	p-GF	
	М	F	В	S	D	So	m-GM	m-GF	p-GM	p-GF	
	М	F	В	S	D	So	m-GM	m-GF	p-GM	p-GF	
	М	F	В	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):

Arbeiner Yes No Migual neutrony (if yes) No Amyotrophic Lateral Sclerosis Yes No Kidney Pailure Yes No Anorexia or Bulimia Yes No Kidney Pailure Yes No Anorexia or Bulimia Yes No Kidney Pailure Yes No Anterix or Bulimia Yes No Kidney Pailure Yes No Anterix or Bulimia Yes No Mailgnancy (if yes, describe below) Yes No Arthoritis Yes No Mainganacy (if yes, describe below) Yes No Attrimme Disease Yes No Muscular Dystophy Yes No Bloeding Disorder Yes No Ostaroctros No Ostaroctros No Cataracts Yes No Osteoporosis Yes No Corgan Transplant (if yes, describe below) Yes No Congenital Heart Defects Yes No Patreatitis Yes No Corgenital Heart Defects Yes No Periodic Limb Movement Disorder Yes No	Adrenal Dysfunction	🗌 Yes 🗌 No	Irregular Heart Rhythm	🗌 Yes 🔲 No
Amyotrophic Lateral Sclerosis Yes No Liver Dysfunction Yes No Anorexia or Bulimia Yes No Kidney Failure Yes No Anterovenous Malformations Yes No Malignancy (if yes, describe below) Yes No Arterovenous Malformations Yes No Malignancy (if yes, describe below) Yes No Arthritis Yes No Mariai Yes No Autoinmune Disease Yes No Muscular Dystrophy Yes No Bipolar Disorder Yes No Muscular Dystrophy Yes No Catracts Yes No Ostructive Sleep Apnea Yes No Cludication Yes No Ostructive Sleep Apnea Yes No Cludication Yes No Ostructive Sleep Apnea Yes No Cludiation Yes No Pacreatitis Yes No Cludiation Yes No Pacreatitis Yes No Corporter Yes No Periodic1 Limb Movement Disor	-		s ,	
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HemorrhoidsYesNoThrombocytopeniaYesNoHepatitisYesNoThrombophiliaYesNoHIV or AIDSYesNoTransfusionsYesNoHypertensionYesNoTuberculosisYesNo	Heart or Valve Defects	🗌 Yes 🗌 No	Skin Disorders (Psoriasis, Acne, etc.)	🗌 Yes 🗌 No
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Hypertension 🗌 Yes 🗋 No Tuberculosis 🗌 Yes 🗋 No		🗌 Yes 🔲 No		🗌 Yes 🔲 No
	51 			
Hypotension 🗌 Yes 🗌 No Urinary Retention or Urgency 🗌 Yes 🗌 No			•	
Hypotension Yes No Vasculitis Yes No				
Inflammatory Bowel Disease I Yes I No Visual Defects I Yes No				
Visual Defects Visual				

3

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	YesNo
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 No
Food intolerance	Yes	No No
Frequent skin sores	🗌 Yes	🗌 No
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