



LifeScreen Imaging, PLLC

Medical History Questionnaire

Name: _____ Sex: M F Age: _____ DOB: ____/____/____

Name of Primary Care physician: _____

Address/phone#: _____

Please indicate reason for having today's exam: _____

Current Medical History:

If yes, please specify

Are you currently under a physician's care? Yes / No _____

Are you currently taking any medications? Yes / No _____

Any previous surgeries? Yes / No _____

Any significant past health problems? Yes / No _____

Have you had any prior CT scans or other radiology tests (x-rays, ultrasound, MRI, etc.) that pertain to the area/areas we are imaging today? _____

Current Conditions:

High Blood Pressure Yes / No _____

Diabetes Yes / No _____

High Cholesterol Yes / No _____

Known Heart Disease Yes / No _____

Known Vascular Disease Yes / No _____

Post Menopausal Yes / No _____

Cancer Yes / No _____

Weight _____ lbs (optional)

Family History:

Relative or Self

Coronary Artery Disease (CAD)	Yes / No	_____
Heart Disease	Yes / No	_____
High Cholesterol	Yes / No	_____
Stroke	Yes / No	_____
Heart Attack	Yes / No	_____
High Blood Pressure	Yes / No	_____
Cancer	Yes / No	_____
Diabetes	Yes / No	_____
Colitis	Yes / No	_____
Kidney Disease	Yes / No	_____
Thyroid Disease	Yes / No	_____
Other	Yes / No	_____

Social History:

Current Smoker # of Years: _____ Packs per day _____

Previous Smoker? _____ # of years: _____ Packs per day: _____

Year that you quit: _____

Pregnant? _____ # of months: _____

Activity Level: Rate 1 – 5 (5 being the highest) _____

Patient's Signature: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____