



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: \_\_\_\_/\_\_\_\_/\_\_\_\_