utmb Health
Radiology

SCHOOL OF MEDICINE
Division of Interventional Radiology

PERSONAL INFORMATION:

_____ ____ _____ _____
Last Name *MI* *First Name* *Date of Birth*

Reason for Visit: _____**Referring MD:**_____

History of current illness_____

Past Medical History: _____

_____***Glaucoma?*** _____

Past Surgical History: _____/_____/_____
Type *Year* *Type* *Year* *Type* *Year*

FAMILY HISTORY: (*Family Member Who Has Had Any of the Following Conditions)*:

Cancer (Type): _____ **Heart Disease:** _____ **Bleeding Disorder:** _____

ALLERGIES: _____ _____ _____
Name of Medication/Reaction *Name of Medication/Reaction* *Name of Medication/Reaction*

SOCIAL HISTORY: (*please circle correct response)*

Tobacco use: Y or N_____ **Alcohol use: Y or N**_____ **Illicit drugs: Y or N** _____**Caffeine**_____
Packs per day? ***Drinks per day?*** ***Type?*** ***Times per day?***

MEDICATIONS:

_____ _____
Name of Medication/ Strength/How Many Times Per Day ***Name of Medication/ Strength/How Many Times Per Day***

_____ _____
Name of Medication/ Strength/How Many Times Per Day ***Name of Medication/ Strength/How Many Times Per Day***

_____ _____
Name of Medication/ Strength/How Many Times Per Day ***Name of Medication/ Strength/How Many Times Per Day***

_____ _____
Name of Medication/Strength/How Many Times Per Day ***Name of Medication/ Strength/How Many Times Per Day***

_____ _____
Name of Medication/Strength/How Many Times Per Day ***Name of Medication/ Strength/How Many Times Per Day***

REVIEW OF SYSTEMS: ***(please check all that apply)***

General- **□ Weight loss or gain** **□ Fatigue** **□ Fever or chills** **□ Weakness** **Skin-** **□ Rashes** **□ Lumps** **□ Itching** **□ Dryness** **Head-** **□ Headache** **□ Head injury** **□ Neck Pain** **Ears-** **□ Decreased hearing** **□ Ringing in ears** **□ Earache** **□ Drainage** **Eyes-** **□ Vision Loss/Changes** **□ Glasses or contacts** **□ Pain** **□ Redness** **□ Blurry or double vision** **□ Glaucoma** **□ Cataracts** **Nose-** **□ Stuffiness** **□ Discharge** **□ Itching** **□ Hay fever** **□ Nosebleeds** **Throat-** **□ Bleeding** **□ Dentures** **□ Dry mouth**	**Neck-** **□ Swollen glands** **□ Pain** **□ Stiffness** **Respiratory-** **□ Cough** **□ Sputum** **□ Coughing up blood** **□ Shortness of breath** **□ Wheezing** **□ Painful breathing** **Cardiovascular-** **□ Chest pain or discomfort** **□ Tightness** **□ Palpitations** **□ Shortness of breath with activity** **□ Difficulty breathing lying down** **□ Swelling** **□ Sudden awakening from sleep with shortness of breath** **Gastrointestinal-** **□ Swallowing difficulties** **□ Heartburn** **□ Nausea** **□ Change in bowel habits** **□ Rectal bleeding** **□ Constipation** **□ Diarrhea** **Urinary-** **□ Frequency** **□ Urgency** **□ Burning or pain** **□ Blood in urine** **□ Incontinence** **□ Change in urinary stream**	**Musculoskeletal-** **□ Muscle or joint pain** **□ Stiffness** **□ Back pain** **Neurologic-** **□ Dizziness** **□ Fainting** **□ Seizures** **□ Weakness** **□ Numbness** **Hematologic-** **□ Ease of bruising** **□ Ease of bleeding** **Endocrine-** **□ Head or cold intolerance** **□ Sweating** **□ Frequent urination** **□ Thirst** **□ Change in appetite** **Psychiatric-** **□ Nervousness** **□ Stress** **□ Depression** **□ Memory loss**

For Nurses Use:

VS B/P_____ HR _____ RR_____ T_____ O2sat_____