Radiology Associates of Venice & Englewood
512-516 Nokomis Avenue South, Venice, FL 34285
(941)488-7781 Fax (941)486-0349

Patient Name:_____ DOB:_____Date:_____
Reason for Visit:_____
Referring Dr:_____ Primary Dr:_____

Past Medical History Check (√) all that apply

□ Alcoholism	□ Deep Vein Thrombosis	□ High blood pressure	□ Multiple sclerosis
□ Anemia	□ Diabetes	□ High cholesterol	□ Murmurs
□ Arthritis	□ Emphysema	□ HIV positive	□ Osteoporosis
□ Asthma	□ Epilepsy	□ Insomnia	□ Pacemaker
□ Blood disorders	□ Fracture _____	□ Kidney disease	□ Palpitations
□ Blood Clots	□ GERD	□ Kidney Stones	□ PVD
□ Cancer(Type)_____	□ Glaucoma	□ Liver Cirrhosis	□ Pulmonary Embolism
□ Cataracts	□ Gout	□ Liver disease	□ Sleep Apnea
□ Chemical dependency	□ Heart disease	□ Meningitis	□ Stroke
□ Congestive heart failure	□ Hepatitis	□ Migraine / Headaches	□ Thyroid problems
□ COPD	□ Hernia	□ Mitral Valve Prolapse	□ Tuberculosis

Past Surgical History

Surgery:	Date:	Surgery:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History Circle those that apply

Disease:	Relative:	Disease:	Relative:
Diabetes(type)_____	_____	Osteoporosis	_____
Heart Disease	_____	Peripheral Vascular Disease	_____
High Blood Pressure	_____	Cancer(type)_____	_____
Kidney Disease	_____	Cancer(type)_____	_____
Stroke / TIA	_____	Cancer(type)_____	_____

Father: Living / Deceased Age _____ Cause of Death _____
Mother: Living / Deceased Age _____ Cause of Death _____
Brother(s): #Alive_____ #Deceased_____ Sister(s): #Alive_____ #Deceased_____

Social History

Have you ever used tobacco? Yes / No (Type)_____ How often?_____ Year quit?_____
Are you currently taking any herbal drugs? Yes / No Drug name:_____
Do you drink alcohol? Yes / No How much?_____
Do you exercise? Yes / No How often?_____ Duration_____
Occupation: _____ Retired? Yes / No
Marital status: _____ Does anyone else live in your home?_____

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Allergies / Reactions

☐ NONE ☐ MEDICATIONS ☐ LATEX ☐ IV DYE/CONTRAST ☐ PROBLEMS WITH ANESTHESIA

List Allergies and Reactions:

_____

Prescriptions/ Non-Prescription Medications / Vitamins / Supplements

Medication	Dose/# per day	Medication	Dose/# per day
1._____		7._____	
2._____		8._____	
3._____		9._____	
4._____		10._____	
5._____		11._____	
6._____		12._____	

Vaccinations: Influenza Vaccine? Date_____ Pneumonia Vaccine? Date_____

Review of Systems

SYSTEMIC
- ☐ Chills
- ☐ Feeling tired(Malaise)
- ☐ Fever
- ☐ Weight Change
- ☐ Sweats
- ☐ Forgetfulness
- ☐ Headache
- ☐ Other_____

MUSCULOSKELETAL

Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Muscle aches
- ☐ Stiffness of the back
- ☐ Neck Stiffness
- ☐ Other_____

GASTROINTESTINAL
- ☐ Poor Appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Nausea
- ☐ Black or bloody stools
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Other_____

CARDIOVASCULAR
- ☐ Chest pain or discomfort
- ☐ Rapid heart beat
- ☐ Palpitations
- ☐ Cold hands or feet
- ☐ Varicose veins
- ☐ Leg pain while walking
- ☐ Ankle Joint swelling
- ☐ Other_____

EYE, EAR, NOSE, THROAT
- ☐ Blurred vision
- ☐ Itchy eyes
- ☐ Earache
- ☐ Hearing Loss
- ☐ Ringing in the ears
- ☐ Nosebleeds
- ☐ Hoarseness
- ☐ Throat pain
- ☐ Difficulty swallowing
- ☐ Other_____

SKIN
- ☐ Bruise easily
- ☐ Itching
- ☐ Rash
- ☐ Other_____

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Other_____

PULMONARY
- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Other_____

NEUROLOGICAL
- ☐ Dizziness
- ☐ Fainting (syncope)
- ☐ Vertigo
- ☐ Motor Disturbances
- ☐ Sensory Disturbances
- ☐ Other_____

PSYCHOLOGICAL
- ☐ Difficulty sleeping
- ☐ Anxiety
- ☐ Depression
- ☐ Other_____

ENDOCRINE
- ☐ Excessive sweating
- ☐ Excessive thirst

OFFICE USE ONLY:

BP_____/_____ Pulse_____ 02 SATS_____TEMP_____ RESP_____ HT_____ WT_____