ZOOM
DIAGNOSTIC IMAGING

Which body part(s) will be examined today?

Abdomen	☐												
Brain	☐	Shoulder	Right	☐	Left	☐		Hip	Right	☐	Left	☐	
Chest	☐	Elbow	Right	☐	Left	☐		Thigh	Right	☐	Left	☐	
Jaw	☐	Forearm	Right	☐	Left	☐		Knee	Right	☐	Left	☐	
Pelvis	☐	Wrist	Right	☐	Left	☐		Lower Leg	Right	☐	Left	☐	
Cervial Spine/Neck	☐	Hand	Right	☐	Left	☐		Ankle	Right	☐	Left	☐	
Thoracic Spine	☐	Other_____						Foot	Right	☐	Left	☐	
Lumbar Spine	☐												

Explain the medical problems that have led to the need for this scan:_____

_____

How long have you had this problem:_____

Have you had a recent injury/trauma to this area:_____

List previous surgeries and dates of surgery to the area of concern:_____

Specify if you have had any previous physical/conservative therapy:_____

Specify if you have been treated for any medical illness or disease:_____

Please list all allergies:_____

Do you have a history or currently have any of the following:

☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Ventricular Tachycardia
☐ Yes	☐ No	Kidney Failure, Renal Disease, Renal Surgery	☐ Yes	☐ No	Sino Arterial Dysfunction
☐ Yes	☐ No	Sickle Cell Anemia	☐ Yes	☐ No	Seizures
☐ Yes	☐ No	Multiple Myeloma	☐ Yes	☐ No	Headaches
☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Dizziness
☐ Yes	☐ No	Chemotherapy or Radiation	☐ Yes	☐ No	Severe Debilitation
☐ Yes	☐ No	Pulmonary Hypertension	☐ Yes	☐ No	Memory Loss
☐ Yes	☐ No	Heart Block, Heart Attack, Heart Disease			
☐ Yes	☐ No	Pain, Numbness, Weakness in Extremity ☐ Upper ☐ Lower ☐ Right ☐Left			

Female Patients Only

Are you ☐ using birth control or have you ☐ had a hysterectomy/tubal ligation ☐ gone through menopause
Is there any possibility of pregnancy? ☐ Yes ☐ No When was the first day of your last menstrual cycle?_____

I authorize Zoom Diagnostic Imaging to perform all diagnostic proecdures that were ordered for me by my physician. I hereby release Zoom Diagnostic Imaging from any and all liability pertaining to the performance of diagnostic imaging procedures. Furthermore I understand and agree that Zoom Diagnostic Imaging is released from all liability and litigation pertaining to myself, and/or my unborn child. I have ben informed of the current risks to myself and to my unborn child (if pregnant) if exposed to radiation from a CT scan, X-Ray and/or oral contrast. While it is currently accepted that ultrasound and MRI are not proven to be harmful to to release Zoom Diagnostic Imaging from any and all liabilities.

_____ _____
Patient/Guardian Signature Date

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity ot ask questions regarding the information on this form.

_____ _____
Patient/Guardian Signature Date