UNIVERSITY RADIOLOGY

University Radiology Interventional and NeuroInterventional Radiology Clinic Patient Registration Forms

865-558-0225

Please Print Clearly

Patient Name: _____ Date: _____
First Middle Last

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birthdate: _____ Age: _____ SSN: _____

Occupation: _____ Employer: _____

Years at Employer: _____ Employer Street Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Email: _____

Name of Spouse: _____ Birthdate: _____ Age: _____

SSN: _____ Occupation: _____ Years at Employer: _____

Employer: _____ Employer Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

In Case of Emergency, Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

How did you learn about us? _____

Can we mail information to your home?	Yes	No
Can we leave a message for you at home?	Yes	No
Can we leave a message for you at work?	Yes	No
Can we send email to the address you provided?	Yes	No

_____ _____
Patient Signature Date

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birthdate: _____ Age: _____ SSN: _____

Occupation: _____ Employer: _____

Years at Employer: _____ Employer Street Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Email: _____

Review of Systems

Patient Name: _____ Date: _____

Are you currently having, or have you had, problems with... (Circle Yes or No for all questions)

Constitutional

Fever/Chills/Night Sweats	Yes	No
Weight Loss/Gain	Yes	No
Excess Fatigue	Yes	No

Eyes

Wear Glasses/Contacts - Date of Last Exam: _____	Yes	No
Infections/Injuries	Yes	No
Glaucoma/Cataracts	Yes	No

Ear, Nose, Throat, and Mouth

Wearing Hearing Aids - Date of Last Exam: _____	Yes	No
Hearing Loss	Yes	No
Ear Infections	Yes	No
Ringing in the Ears *Circle:* Left Right Both	Yes	No
Balance Disturbance (e.g. Vertigo, Spinning)	Yes	No
Nosebleeds	Yes	No
Nasal Drainage - Amount _____ Color _____	Yes	No
Inability to Smell	Yes	No
Sinus Problems/Sore Throat	Yes	No
Mouth Sores	Yes	No

Cariovascular/Vascular

Chest Pain or Angina - Date of Last EKG: _____	Yes	No
High Blood Pressure	Yes	No
Irregular Pulse/Heart Murmur	Yes	No
High Cholesterol	Yes	No
Swelling in the Feet or Hands	Yes	No
Leg Pain While Walking	Yes	No

Respiratory

Asthma/Emphysema	Yes	No
Chronic Cough/Bloody Sputum	Yes	No
Shortness of Breath	Yes	No
Bronchitis/Pneumonia	Yes	No
Lung Cancer	Yes	No

Gastrointestinal

Indigestion or Pain with Eating	Yes	No
Nausea/Vomiting	Yes	No
Blood in Your Vomit	Yes	No
Liver Disease/Jaundice	Yes	No
Abdominal Pain	Yes	No
Change in Your Bowel Habits	Yes	No
Ulcers or Gastritis	Yes	No
Colon Cancer	Yes	No

Genitourinary

Urinary Tract Infections	Yes	No
Painful Urination	Yes	No
Blood in Your Urine/Kidney Stones	Yes	No
Difficulty Starting or Stopping Stream	Yes	No
Incontinence	Yes	No
Prostate Cancer (Males)	Yes	No
Endometriosis/Cervical Cancer (Females) - Date of Last PAP: _____	Yes	No

Are you currently having, or have you had, problems with... (Circle Yes or No for all questions)

Musculoskeletal

Broken Bones - List: _____	Yes	No
Arm or Leg Weakness	Yes	No
Joint Pain or Swelling	Yes	No
Arthritis	Yes	No

Integumentary

Skin Disease/Cancer	Yes	No
Breast Pain/Tenderness/Swelling/Nipple Discharge	Yes	No
Date and Result of Last Mammogram: _____	Yes	No

Neurological

Fainting Spells/Disorientation	Yes	No
Seizures	Yes	No
Problems with Your Memory	Yes	No
Difficulty with Your Speech	Yes	No
Inability to Concentrate	Yes	No
Double or Blurred Vision	Yes	No
Face Weakness	Yes	No
Coordination in Arm and/or Legs	Yes	No

Psychiatric

Anxiety/Depression	Yes	No
Other Psychiatric Disorder/Treatment: _____	Yes	No

Endocrine

Diabetes/Thyroid Disease	Yes	No
Increased Appetite	Yes	No
Excessive Thirst or Urination	Yes	No
Hormone Problems	Yes	No

Hematology/Lymphatic

Anemia	Yes	No
Hemophilia	Yes	No
Bleeding Tendencies	Yes	No
Persistent Swollen Glands or Lymph Nodes	Yes	No
Blood Transfusion If yes, when? _____	Yes	No

Allergic/Immunology

Food/Inhalant (Nasal) Allergies	Yes	No
Immunologic Disorders	Yes	No

The above information is accurate to the best of my knowledge.

_____ _____

Patient Signature Date

I have reviewed the above information with the patient.

_____ _____

Physician Signature Date

_____

Print Physician Name

Patient Health History Form

Patient Name: _____ Date: _____

Chief Complaint

Reason for today's visit? _____

Referring Physician: _____

Primary Care Physician: _____

Past History

Please List Any Prior Major Illness and/or Injuries Surgeries/Hospitalizations	Year	Complications

Have you ever had problems with anesthesia? _____ Yes _____ No

Medications	**Dose**	**Frequency**

Allergies to Medications: _____

Patient Health History Form Continued ...

Patient Name: _____ Date: _____

Family Member	Alive	Deceased	Age	Health Status or Cause of Death
Grandmother (Maternal)	A	D		
Grandmother (Paternal)	A	D		
Grandfather (Maternal)	A	D		
Grandfather (Paternal)	A	D		
Mother	A	D		
Father	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Social History

Occupation: _____

Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed

Do you have children? _____ Yes _____ No If yes, how many? _____

Do you live alone? _____ Yes _____ No Who lives with you? _____

Do you smoke?
_____ Yes, I've smoked _____ packs of cigarettes per day for _____ years
_____ Yes, I smoke cigars/pipe or chewing tobacco
_____ No, I quit _____ years ago. At the time I was smoking _____ packs a day for _____ years.
_____ No , I have never smoked

Do you drink alcohol?
_____ No (never or rarely)
_____ No, but I used to
_____ Yes _____ Daily _____ 1 or more times a week _____ 1 or more times a month

Are you at risk for HIV/AIDS (e.g. sexual orientation, drug abuse, previous blood transfusion)?
_____ No
_____ Yes (The physician will discuss with you during your visit.)