Inland Empire Imaging Center
260 E Ontario Ave. Suite 101A. Corona CA. 92879
tel: 951 284 1920 fax: 951 284 1921

PATIENT MEDICAL HISTORY

1) **NAME:**_____ _____ _____ **TODAYS DATE:** _____/_____/_____
first MI last

2) **BIRTH DATE:**_____/_____/_____ **HEIGHT:**_____ **WEIGHT:**_____

3) **Who are your primary care physician?** _____

4) **Who is your referring physician?**_____

5) **Do you have diabetes?** ☐ **Yes** ☐ **No**
If Yes, is it controlled? ☐ **Yes** ☐ **No**
What kind of medication do you take? ☐ **Insulin** ☐ **Other:** _____

6) **Have you been diagnosed with any kind of cancer?** ☐ **Yes** ☐ **No**
If yes, when was the diagnosis made for the first time?_____/_____/_____
If yes, what kind of cancer do you have?

☐ **Head and neck** ☐ **Lung** ☐ **Breast** ☐ **Esophageal** ☐ **Hodgkin's disease**
☐ **Lymphoma** ☐ **Melanoma** ☐ **Colorectal** ☐ **Other:** _____

7) **Was surgery performed** ☐ **Yes** ☐ **No** ☐ **If yes, when:**_____

8) **Have you had a biopsy?** ☐ **Yes** ☐ **No** **When:**_____ **Where:**_____

9) **Have you had a PET/CT, CT, or MRI scan?** ☐ **Yes** ☐ **No**
If yes, where? _____

10) **Have you had chemotherapy?** ☐ **Yes** ☐ **No** ☐ **In progress** ☐ **Completed**_____
month / year

11) **Have you had Radiation therapy?** ☐ **Yes** ☐ **No** ☐ **In progress** ☐ **Completed**_____
month / year

12) **Have you had any recent surgery?** ☐ **Yes** ☐ **No**
If Yes, **Where:**_____ **What kind:**_____

13) **Any history of lung disease, such as tuberculosis, sarcoidosis, etc?** ☐ **Yes** ☐ **No**

14) **Have you had any recent infection?** ☐ **Yes** ☐ **No**
If Yes, **When:**_____ **What kind:**_____
If Yes, have you been treated for the infection? ☐ **Yes** ☐ **No**
If Yes, is it cured now? ☐ **Yes** ☐ **No**

15) **(female only) To the best of your knowledge are you pregnant?** ☐ **Yes** ☐ **No**

16) **Who is the physician you are going to see regarding your condition?**_____

17) **When are you scheduled to see a physician regarding your condition?**_____

_____ _____/_____/_____
PATIENT SIGNATURE DATE