Guam Radiology Consultants — PROCEDURE CONSULTATION

Reason for referral:

Patient's Medical History Please MARK Yes or No if you have a history of any of the following:

Heart & Lungs:	**Yes**	**No**	**Nerves/Muscles:**	**Yes**	**No**	**GI/General**	**Yes**	**No**
Heart Attack/Failure	__	__	Stroke	__	__	GERD/Heartburn	__	__
Heart Valve/ Stent	__	__	Seizures	__	__	Cirrhosis	__	__
Abnormal Cholesterol	__	__	Spina Bifida	__	__	Irritable Bowel/Colitis	__	__
High Blood Pressure	__	__	Depression	__	__	Colon Disease	__	__
Fibrillation/Pacemaker	__	__	Multiple Sclerosis	__	__	Diabetes	__	__
Heart Murmur	__	__	Arthritis	__	__	Thyroid Disease	__	__
Rheumatic Fever	__	__	Fibromyalgia	__	__	Kidney Stone	__	__
Asthma /Emphysema	__	__	Blood Clot in Legs	__	__	Renal Failure	__	__

Have you ever had?

TB	__	__	HIV	__	__	Cancer	__	__
AIDS	__	__	Hepatitis	__	__	Radiation/Chemotherapy	__	__

Any ILLNESS that is NOT LISTED ABOVE: _____

PAST Surgical History: Type of Surgery and dates: _____

Do you take antibiotics prior to any procedure? **Yes** **No** If YES, name: _____

Review of Current or recent Symptoms: Please MARK Yes or No if you have any of the following:

	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Fever/Chills	__	__	Shortness of breath	__	__	Dizziness	__	__
Weight Loss	__	__	Productive/bloody cough	__	__	Sleep Problems	__	__
Headaches	__	__	Flank pain	__	__	Chronic Fatigue	__	__
Chest pain/angina	__	__	Blood in Urine	__	__	Neck Problems	__	__
Palpitation/racing heart	__	__	Painful urination	__	__	Numbness/tingling	__	__
Wheezing	__	__	Frequent urination	__	__	Loss of strength	__	__

Any condition/s that is NOT LISTED ABOVE: _____

Family Health History: Please MARK Yes or No. If YES, please indicate which **family member**

	Yes	**No**		**Yes**	**No**
Any Cancer	__	__	Bleeding Problems	__	__
Heart Problems/Sudden Death	__	__	Reaction to Anesthesia	__	__
Diabetes	__	__	Asthma/Breathing Problems	__	__

Parents- Any illness/health condition? Father _____ Mother _____

If deceased, age and cause of death: Father _____ Mother _____

Any significant illness in close family members: _____

Social History:

	Yes	**No**		
Do you or did you use tobacco?	__	__	If yes, pack/s per day & how long	_____
Have you stopped using tobacco?	__	__	If Yes when did you stop	_____
Do/Did you drink Alcoholic beverage?	__	__	If yes, how much per day	_____ If stopped, when? _____
Do/Did you use recreational drugs?	__	__	If yes, what kind	_____
Do/Did you have sexually transmitted disease	__	__	If yes, what kind	_____
Do you have religious or personal beliefs that may limit us from performing this procedure?				_____

Working/Retired Occupation: _____

Married/Single/Divorced No of children: _____ Any Illness/Deceased? _____

PATIENT NAME: **PATIENT'S SIGNATURE:** **DATE:**

_____ _____ _____