CRA MEDICAL IMAGING

Medical Imaging Center
Crouse Medical Imaging Services
Diagnostic Imaging Center

Name_____**Date of Birth**_____

Address_____
Street **City** **State** **Zip Code**

Phone Numbers: **Email address**_____
Please check box for preferred contact
- ☐ Cell ( )_____
- ☐ Home ( )_____

Preferred Language:
- ☐ English
- ☐ French
- ☐ Spanish
- ☐ Vietnamese
- ☐ Italian
- ☐ Polish
- ☐ Other_____

Race:
- ☐ White
- ☐ Black or African-American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Multi-racial
- ☐ Declined ☐ Other_____

Ethnicity: Are you from Hispanic or Latino Ancestry?
- ☐ Yes
- ☐ No
- ☐ Unknown or Declined

Smoking Status:
- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former Smoker
- ☐ Never Smoked

Do you have any medication allergies or an allergy to Latex?
☐ NO ☐ YES (please include allergy ***and*** reaction)_____

Are you Diabetic?
☐ NO ☐ YES (please list your medications related to Diabetes)_____

Are you on a medication that contains *Metformin*? ☐ NO ☐ YES

Are you taking any of the following types of medications? If Yes→ please indicate name and dosage:

Blood thinners (e.g. Plavix, Coumadin) ☐ NO ☐ YES_____

Blood Pressure medications ☐ NO ☐ YES_____

Date you last received the Flu vaccine? Month/ Year_____ ☐ Never had the flu vaccine

Date you last received the Pneumonia vaccine? Month/ Year_____ ☐ Never had the pneumonia vaccine

Females:
Is there any chance you are pregnant? ☐ NO ☐ YES
Are you breastfeeding? ☐ NO ☐ YES
Have you had a mammogram anywhere in the last 2 years? ☐ NO ☐ YES

_____ _____
Signature **Date**

_____
Legal Authorized Representative

Reviewed by_____**(Tech initials)**