

Community Medical Center
Department of Radiology

Date: _____

Patient History Questionnaire

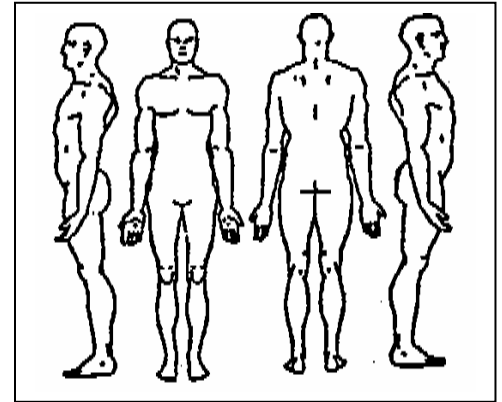
Patient Name: _____ DOB: _____ Weight: _____

Reason for Procedure:

Please check any of the following symptoms related to today's test:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nausea | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Pelvic Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Unexpected Weight Loss | | |
| <input type="checkbox"/> Shoulder Pain (<input type="checkbox"/> Right/ <input type="checkbox"/> Left) | | <input type="checkbox"/> Leg Pain (<input type="checkbox"/> Right/ <input type="checkbox"/> Left) | |
| <input type="checkbox"/> Arm Pain (<input type="checkbox"/> Right/ <input type="checkbox"/> Left) | | <input type="checkbox"/> Numbness (<input type="checkbox"/> Right side/ <input type="checkbox"/> Left side) | |
| <input type="checkbox"/> Weakness (<input type="checkbox"/> Right side/ <input type="checkbox"/> Left side) | | | |

How and when did these symptoms occur (e.g., injury, just started, etc.) _____



LEFT FRONT BACK RIGHT

Please identify the location of any pain/numbness/lump

Medical History:

1. Do you have or have you had any of the following?

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney/Renal Disease | <input type="checkbox"/> Multiple Myeloma | <input type="checkbox"/> Tumor, lump or mass |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sickle Cell Anemia | |
| <input type="checkbox"/> Asthma, bronchitis or emphysema | <input type="checkbox"/> Other illness/disease: _____ | | |

2. Have you had any tests (MRI, CT, X-Ray, etc.) performed for the symptoms you are currently experiencing? Yes No
If yes, please list the date, type and who performed the test: _____

3. Have you had any surgeries or therapies (e.g., radiation therapy, chemotherapy, etc.) Yes No
If yes, please list the date and type of surgery or therapy: _____

4. Are you currently taking any medications? Glucophage Metformin Glyburide
If yes, please list all medications you are currently taking on the attached form.

5. Do you have any allergies (e.g. medications, latex, food, etc.)? Yes No
If yes, please list all allergies: _____

6. When is your next appointment with the physician that ordered this procedure? _____

7. Females only: Are you or is it possible you may be pregnant? Yes No Don't know
Breast Feeding? Yes No First day of last period (LMP) _____

I hereby certify that the above information is true and to the best of my knowledge.

Patient or Legal Representative Signature Print Name and Authority (if legal representative) Date

Technologist Notes: _____