

PATIENT QUESTIONNAIRE

The information you provide will enable our radiologist to interpret your imaging study more accurately. Thank you.

1. What are your current symptoms that are relevant to today's imaging study? _____

2. Circle your pain level: 0 1 2 3 4 5 6 7 8 9 10
3. Were you injured? Yes No
When were you injured? _____
How were you injured? _____

4. Have you had cancer? Yes No What type(s)? _____
When was it diagnosed? _____
Cancer surgery? Yes No Date? _____ Describe _____
Chemotherapy? Yes No Date? _____
Radiation therapy? Yes No Date? _____
Is it in remission? Yes No Unsure
5. Have you had surgery on the part of the body that we are imaging today? Yes No
Type of surgery? _____
Date of surgery? _____
6. Circle all that you have: Diabetes Hypertension Emphysema COPD Asthma
Stroke Heart problem Liver problem Kidney condition
Other (specify) _____

7. Do you smoke currently? Yes No How many years have you smoked? _____ years
If no, have you ever smoked? Yes No How many years did you smoke? _____ years

Patient Signature

7130115 (4/13)



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Where are your symptoms relevant to today's study? If no symptoms, check here.

Write these letters on the diagram below:

X = Where you hurt the most **P** = Pain **N** = Numbness **W** = Weakness

