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
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