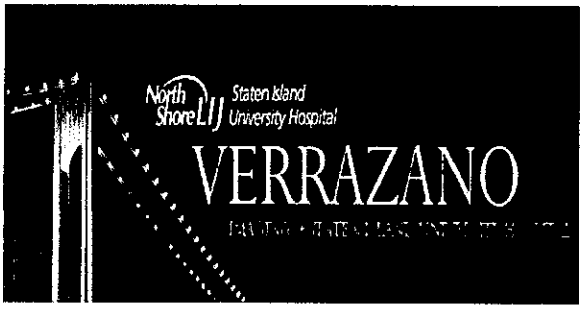

Pt. Name_____

Date of Birth _____/_____/_____

Today's Date_____/_____/_____

RADIOLOGY QUESTIONNAIRE

What type of exam are you having today?

_____

Why are you having this test and what are your symptoms?

_____

_____

Do you have pain? □ Yes □ No If Yes, please specify

_____

Please list current medical conditions: Please list prior surgeries with dates:

_____

_____

Do you have a history of cancer? □ Yes □ No
If yes, please specify:_____
Have you ever received radiation therapy? □ Yes □ No
If yes, to what area?_____

If female, are you, or is there a chance you may be pregnant? □ Yes □ No
When was your last menstrual period? _____

_____ _____
Signature of patient (or parent if patient is a minor) Date