



### Questionnaire

Cell Phones: When a technologist calls your name, please turn off your cell phone.

To assist the radiologist in interpreting your study and help the technologist perform the correct exam for you, please answer the following medical questions:

What doctor ordered your exam for today? \_\_\_\_\_

What procedure are you having today? CT  
MRI  
PET  
Other \_\_\_\_\_

1. Have you personally ever been diagnosed with cancer? Yes No

If yes, in what part of your body? \_\_\_\_\_

When were you diagnosed? \_\_\_\_\_

2. List any surgery pertaining to the area we are imaging today:  
\_\_\_\_\_

3. Have you had a radiation therapy for cancer? Yes No

If yes, when was it completed? \_\_\_\_\_

4. Have you had chemotherapy? Yes No

If yes, when was it completed? \_\_\_\_\_

5. Do you have a history of the following?

High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV +	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	(food, medication, etc)	

6. Have you had any of the following tests that pertain to the areas we are imaging today?

At which facility/Approximate Date

Bone Scan             Yes    No

\_\_\_\_\_

CT Scan               Yes    No

\_\_\_\_\_

MRI Scan             Yes    No

\_\_\_\_\_

X-ray                  Yes    No

\_\_\_\_\_

Ultrasound          Yes    No

\_\_\_\_\_

7. Do see your doctor today? If not, then when is your follow-up appointment?

\_\_\_\_\_

8. Is there a possibility you are pregnant?     Yes    No

Nursing                                             Yes    No

9. What is your height? \_\_\_\_\_ Weight? \_\_\_\_\_

10. In regard to this exam, please list any relevant symptoms, also list medications.

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

\_\_\_\_\_  
Signature (Patient or Parent/Guardian)

\_\_\_\_\_  
Date Signed

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Date Revised: \_\_\_\_\_ Patient Initials: \_\_\_\_\_