RADIA®

MRI/CT/XRAY ABDOMEN & PELVIS QUESTIONNAIRE

Please help us make an accurate diagnosis by answering the following questions:

What is your current weight? ___________ (lbs/kgs) What is your height? __________________

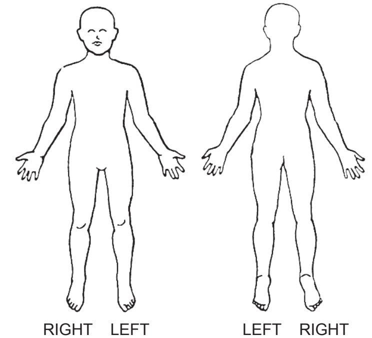
Why did your doctor order this exam?____

❑ Yes ❑ No Are you currently having symptoms?

If yes, what are they? ____

If yes, for how long? __________________________

Please mark location of your symptoms on the diagram. →



❑ Yes ❑ No Do you currently have pain? If yes, for how long? ___________

❑ Yes ❑ No Does your pain radiate?

Where: ____

❑ Yes ❑ No Have you an injury or trauma to the area we are scanning today?

When: _________________ Describe the injury: ____

❑ Yes ❑ No Have you had surgery on the area we are scanning today? When: _____________________

Describe surgery: ____

❑ Yes ❑ No Have you ever had cancer? When: ____________________ Type: _________________________________

❑ Yes ❑ No Do you have blood in your urine? If yes: ❑ Gross (visible) ❑ Microscopic (not visible)

❑ Yes ❑ No Have you ever been diagnosed with Hepatitis? If yes, what type: ____________________________

❑ Yes ❑ No Do you smoke, or have a history of smoking? If yes, number of packs/day: _______

❑ Yes ❑ No Are you diabetic? If yes, do you take insulin? ❑ Yes ❑ No

If you do not take insulin, do you control your diabetes with diet? ❑ Yes ❑ No

❑ Yes ❑ No Do you drink alcohol? If yes, how much and how often? ________________________________

❑ Yes ❑ No Have you had past imaging studies of the area of your body we are scanning today?

Type of imaging study: ____________________ When: ___________ Name of facility: _______________

Type of imaging study: ____________________ When: ___________ Name of facility: _______________

Other medical history we should know about? ____

____

For female patients:

❑ Yes ❑ No Are you pregnant? Date of last menstrual period: _______________________________

❑ Yes ❑ No Are you breast feeding?

❑ Yes ❑ No Are you post-menopausal?

Signature of patient: ____ Date: ________________________

Name of person filling out this form, if other than the patient (please print): ____________________________________

Relationship to patient (please print): ____

Technologist Initials: ___________

Affix Pt Sticker Here

(rev 9/15)