Northeast Radiology

FLUOROSCOPY CLINICAL QUESTIONNAIRE

Name: _____ Date: _____

Allergies: _____

1. Why has your doctor sent you for this test? Did he/she give you a specific diagnosis?

_____
_____
_____
_____

2. Please describe what specific complaints/symptoms have been most bothersome to you?

_____
_____
_____

3. How long have you had these complaints/symptoms? _____

4. Did these complaints/symptoms come on suddenly or gradually? _____

5. These complaints/symptoms have:

_____improved _____remained the same _____worsened

6. Have you had any previous surgery related to today's exam? _____Yes _____No

(If yes, type and date: _____

7. Have you had any prior tests related to today's exam?

MRI	Date: _____	Place: _____
CT Scan	Date: _____	Place: _____
Ultrasound	Date: _____	Place: _____
Nuclear Medicine	Date: _____	Place: _____

Other_____

What were the results of these tests? _____
_____

(over)

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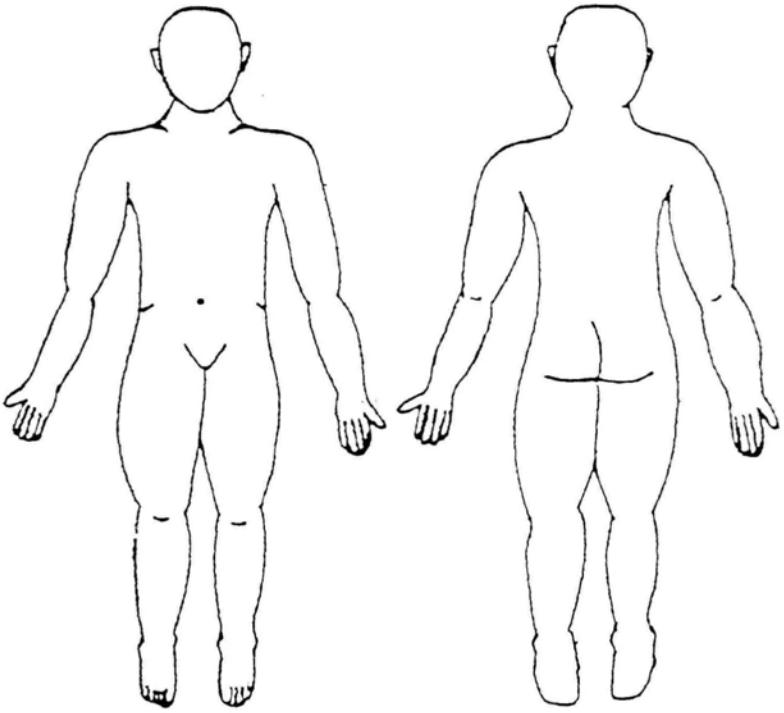
PLEASE SHADE IN THE REGIONS WHICH HURT