X-RAY 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)

X-RAY CLINICAL QUESTIONNAIRE

PLEASE SHADE IN THE REGIONS WHICH HURT