Northeast Radiology

X-RAY / FLUORO / CT / ULTRASOUND
CLINICAL QUESTIONNAIRE

Name: _____ Date: _____

Allergies: _____

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

2. Is today's visit a result of an injury? YES (answer A, B & C) NO (continue to question #3)
YES A. Where did event occur? (home, park) _____
B. When did it occur? (month, day, year) _____
C. How did it occur? (events which led to injury) _____
_____
_____

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

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

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

6. These complaints/symptoms have:

_____improved _____remained the same _____worsened

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

(If yes, type and date: _____

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

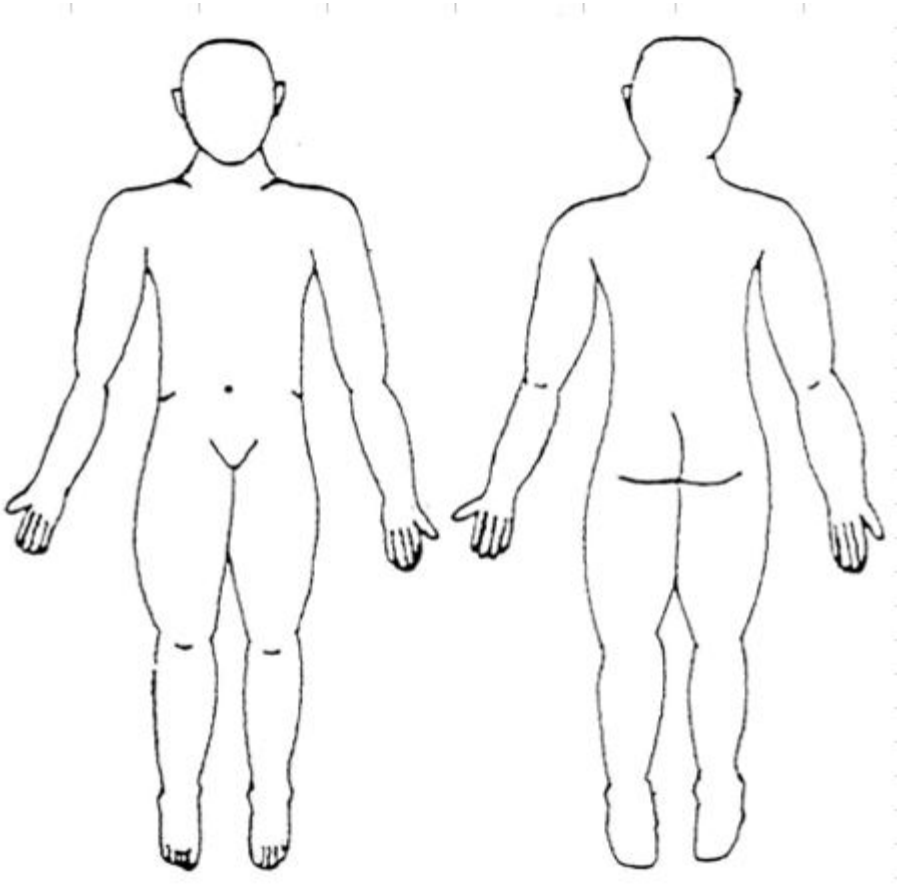
MRI	Date: _____	Place: _____
CT Scan	Date: _____	Place: _____
Ultrasound	Date: _____	Place: _____
Nuclear Medicine	Date: _____	Place: _____

Other_____

What were the results of these tests? _____
_____

(over)

Shade in the regions that hurt



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STAFF USE ONLY

Contrast :
Batch # :
Injection Time:
Injection Site:
Priors:
Tech Notes: