THOUSAND OAKS RADIOLOGY PATIENT HISTORY QUESTIONNAIRE

Date: _____ Sex: _____ Height: _____ Weight: _____ Age: _____ Birth Date: _____

Patient Name: _____ Referring Physician: _____

1.) **Please tell us why you are here today and describe any pain or symptoms.**

_____

_____

_____

2.) When did your pain/symptoms begin?_____

3.) If injured, date of injury and please describe: _____

_____

4.) Please list All previous related surgeries

_____

_____

5.) Any history of smoking? Yes___ No____ How Long?_____

6.) Are you diabetic? Yes____ No ____

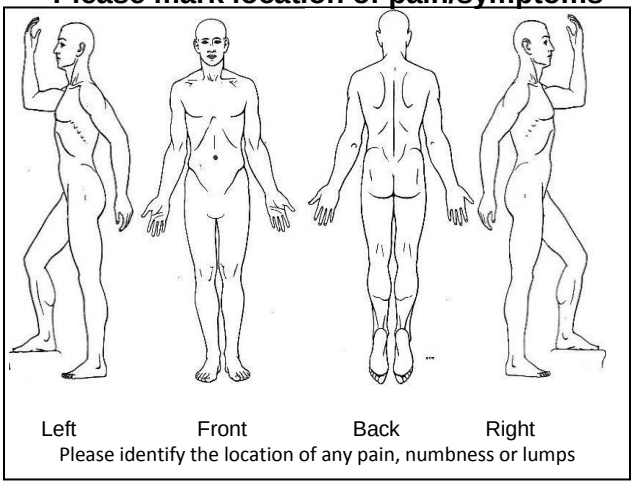
7.) Do you have a history of renal disease? Yes____ No ____

8.) Are you pregnant? Yes____ No ____

9.) Do you have a history of cancer? Yes____ No ____

If yes, when & what type? _____

Please mark location of pain/symptoms



Please identify the location of any pain, numbness or lumps

10.) Are you currently undergoing Radiation or Chemotherapy? Yes_____ No _____

11.) **Any** history of Radiation or Chemotherapy treatments? Yes_____ No_____

12.) Please check **ALL PREVIOUS** studies **RELATED** to the area that we are scanning today.

>Office Use Only?

	Facility	Body Part	Date	CD/Report
CAT/CT Scan				
MRI Scan				
PET Scan				
X-Rays				
Nuclear Medicine				
Ultrasound				
Mammogram				

OFFICE USE ONLY

Tech_____ Rad_____ Oral_____ Exam _____ CTDIvol _____ DLP _____

CC's_____ Discarded_____ Time of injection_____ Exam _____ CTDIvol _____ DLP _____

Exam(s)_____ Exam _____ CTDIvol _____ DLP _____

_____ Exam _____ CTDIvol _____ DLP _____