UNIVERSITY RADIOLOGY

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Date: _____

E-mail: _____ Day Phone: _____ Cell: _____

Date of Birth: _____ Height: _____ Weight: _____ Date of Last Menstrual Period: _____ ☐ N/A

Reason for Exam: _____

Do you have Asthma? ☐ Y ☐ N Are you allergic to: X-ray Dye? ☐ Y ☐ N MRI Dye? ☐ Y ☐ N Latex? ☐ Y ☐ N

Food or Drug Allergies? ☐ Y ☐ N If yes, describe: _____

Do you have Diabetes? ☐ Y ☐ N Do you have Kidney Disease? ☐ Y ☐ N Number of alcoholic drinks per week? _____

Smoking History (please check one box):

☐ Never Smoked ☐ Former Smoker When did you quit? _____

☐ Current Smoker How many years have you smoked? _____ How many packs per day do you usually smoke? _____

Do you have or have you had cancer? ☐ Y ☐ N If yes, what type of cancer? _____

Have you had chemotherapy? ☐ Y ☐ N Radiation Therapy? ☐ Y ☐ N If yes, when? _____

Surgical History (please list surgeries and dates):

☐ Appendix _____ ☐ Brain _____ ☐ Gallbladder _____

☐ Ovaries _____ ☐ Pacemaker _____ ☐ Sinus _____

☐ Spine _____ ☐ Uterus _____ ☐ Other _____

Previous Studies (please list when and where you had the study):

CT Scan ..... ☐ Y ☐ N _____ _____

Mammogram ..... ☐ Y ☐ N _____ _____

MRI Scan ..... ☐ Y ☐ N _____ _____

Nuclear/PET Scan ..... ☐ Y ☐ N _____ _____

Ultrasound ..... ☐ Y ☐ N _____ _____

X-Rays ..... ☐ Y ☐ N _____ _____

Describe Health Conditions You May Have (please describe any known abnormalities or symptoms)

Circulation (heart, high blood pressure, aneurysm, etc) ☐ Y ☐ N _____

Digestive (esophagus, stomach, bowels, etc) ..... ☐ Y ☐ N _____

GYN (ovaries, uterus, etc) ..... ☐ Y ☐ N _____

Nervous System (seizure, stroke, hearing, vision, etc) ☐ Y ☐ N _____

Respiratory (breathing, emphysema, lungs, etc) ..... ☐ Y ☐ N _____

Spine/Back (herniated disk, etc) ..... ☐ Y ☐ N _____

Skeletal System (joints, arthritis, etc) ..... ☐ Y ☐ N _____

Urinary (kidney, kidney stones, bladder, etc) ..... ☐ Y ☐ N _____

Other conditions/symptoms ..... ☐ Y ☐ N _____

Are you in pain? ..... ☐ Y ☐ N Rate your pain on 1-10 scale, where 10 is the worst pain: _____

Current Medications (please list prescription and non-prescription medications)

_____

_____

_____