Quantum Radiology Patient Questionnaire

PATIENT NAME____**DATE**__________

LIST ANY SURGERIES THAT YOU HAVE HAD IN THE LAST FIVE YEARS:

❑	Uterus	❑	Tubes Tied
❑	Appendix	❑	Hernia
❑	Tonsils	❑	Gallbladder
❑	Heart	OTHER ______________	

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Do **YOU** have any of the following conditions?

❑ Diabetes ❑ Arthritis ❑ AIDS

❑ Asthma or Lung ❑ High Blood Pressure

❑ Heart ❑ Cancer ❑ Stroke

❑ Other: ___________________________________

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Do you smoke? ❑ Yes ❑ No

Of packs per day _____ for # of years __________

Do you drink alcohol ❑ Yes ❑ No

If yes, how many drinks per week? ________________

Do you take drugs **NOT** prescribed by a doctor?

❑ Yes ❑ No

Check any of the following that you have had **RECENTLY**:

❑ Fever/chills	❑ Vomiting	❑ Dizziness
❑ Weight Loss	❑ Diarrhea	❑ Numbness
❑ Eye pain	❑ Pain when Urinating	❑ Depression
❑ Drainage from eyes	❑ Frequency of urination	❑ Hallucinations
❑ Ear pain	❑ Phlegm	❑ Excessive thirst
❑ Very tired	❑ Difficulty breathing	❑ Heat or cold intolerance
❑ Weakness	❑ Constipation	❑ Excessive thirst
❑ Recent vision changes	❑ Abdominal pain	❑ Bleed excessively
❑ Nasal congestion or bleeding	❑ Blood from bowels	❑ Joint pain or swelling
❑ Sore throat	❑ Blood in urine	❑ Bruise easily
❑ Chest Pain	❑ Flank pain	❑ Passing out
❑ Heart palpitations	❑ Neck pain	❑ Seizures
❑ Shortness of Breath	❑ Back pain	❑ Anxiety
❑ Ankle swelling	❑ Rash	❑ Suicidal thoughts
❑ Cough	❑ Itching	❑ Excessive urination
❑ Wheezes	❑ Arm pain	❑ Swollen glands
❑ Nausea	❑ Leg pain	❑ Change in skin color
	❑ Headache	

Male:

❑ Testicle pain ❑ Discharge from penis

Female:

Last menstrual period ____________ ❑ Vaginal discharge

# of pregnancies ____________ ❑ Miscarriages

# of live childbirths ____________ ❑ Discharge from breast

❑ Breast pain ❑ Other: ____________________

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