TOWER IMAGING
MEDICAL · GROUP
Imaging by Specialists

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QUESTIONNAIRE FOR IMAGING STUDIES

Date: _____ Name: _____Weight: _____ Date of Birth: _____

Why are you having this test done? Describe your symptoms and duration of symptoms:
(ie. Abdomen pain for 2 weeks) _____

_____

Other relevant exams that have been performed (CT, MRI, X-Ray, Ultrasound, Nuclear Medicine, Labs)
List the type of exam / date of exam / name of facility exam was performed _____

_____

List surgical history and dates: _____

_____

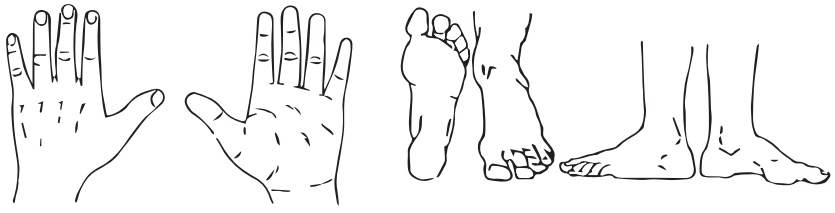
List medications you are taking and what are they for: _____

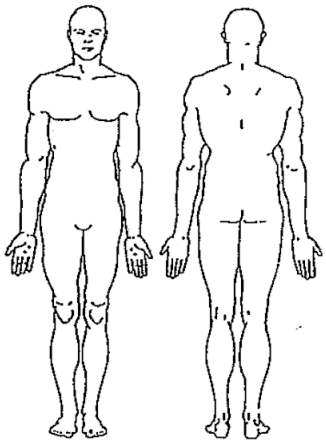
_____

Pregnant	❑ Yes	❑ No	
Smoking	❑ Yes	❑ No	(if yes) ❍ former smoker ❍ current smoker
Iodine Allergy	❑ Yes	❑ No	(if yes) What type?_____
Food/Medicine Allergy	❑ Yes	❑ No	(if yes) What type?_____
Asthma	❑ Yes	❑ No	
Diabetes	❑ Yes	❑ No	(if yes) What medication are you taking?_____
Kidney Failure	❑ Yes	❑ No	
High Blood Pressure	❑ Yes	❑ No	(if yes) ❍ controlled by diet ❍ controlled by medicine
Heart Trouble	❑ Yes	❑ No	
Cancer	❑ Yes	❑ No	(if yes) What part of the body was affected?_____

Please circle the area of concern (injury or symptoms) Make the circles as small as possible to pinpoint the area of concern.

❑ Right Hand ❑ Left Hand ❑ Right Foot ❑ Left Foot





Side: effected side of injury or symptoms ❑ Right Side ❑ Left Side ❑ Both Sides

Duration: ❑ Acute (short term condition) OR ❑ Chronic (long term condition)

Episode of Care: ❑ **Initial** (new injury or new symptoms)
❑ **Subsequent** (follow up of existing injury or symptoms)
❑ **Sequela** (late effects of old injury or symptoms)