TOWER IMAGING
VALENCIA
Imaging by Specialists

23929 McBean Pkwy, Ste. #109
Valencia, CA 91355
Telephone: 661.753.5400
Fax: 661.753.5401

QUESTIONNAIRE FOR IMAGING STUDIES

Date: _____ Name: _____Weight: _____ Date of Birth: _____ Gender: M / F

What area is being imaged today? _____

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

Cause of injury? _____

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: _____
_____

How many CT and Nuclear Cardiac scans have you had in the last 12 months? _____

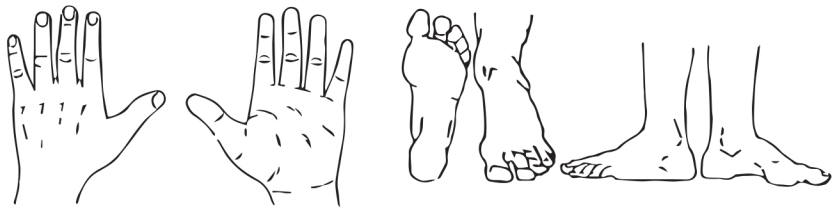
Have you ever been diagnosed with cancer? _____

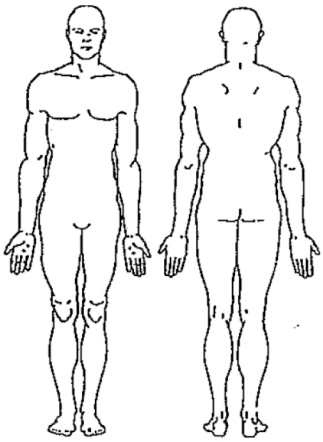
If Yes, what body part was affected? _____ Are you finished with the treatment? _____

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	

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)