

Columbia-Presbyterian Eastside Radiology Patient Questionnaire

In an effort to serve you better, we ask that you answer the questions below. The radiologist will use this information to provide the best interpretation of any finding on the examination that you have.

If you would like to purchase a copy of your study on a CD for your personal records, please inform the front desk. CD fee: \$35.00

Why did your doctor request this exam (for example, because of pain or abnormal blood test or other abnormal test)?

In case we should have to contact you about this exam, please provide contact information (phone, mailing address, or email):

If you are having pain, exactly where is it greatest (for example, the inside part of the right knee or the base of the third finger or the left side of head)?

For how long have you experienced it? _____

Describe any injury to the area. _____

Before today, have you had any radiology study of the area being examined now? _____

If so, ever at a Columbia site? _____

What type of study was performed (x-ray, CT, MRI, ultrasound etc.)? _____

Have you had surgery in the area being studied today? _____ If yes, when? _____

Have you had cancer? _____ If yes, what type? _____

Have you had radiotherapy to the area being studied today? _____

List any allergies: _____

Are you or could you be pregnant? YES () NO ()
Inform the technologist if you are or think you are pregnant.

PLEASE COMPLETE QUESTIONS IN THIS BOX IF YOU ARE HAVING AN MRI.

Do you have a cardiac pacemaker? YES _____ NO _____ Metal in your eyes? YES _____ NO _____

Do you have brain aneurysm clips? YES _____ NO _____

Do you have any of the following?	YES	NO	YES	NO
Metal fragments (bullets etc.).....	_____	_____	_____	_____
Metal plates or screws.....	_____	_____	_____	_____
Cochlear implants.....	_____	_____	_____	_____
Joint replacement.....	_____	_____	_____	_____
Heart valve or previous heart surgery.....	_____	_____	_____	_____
			neurostimulator.....	_____
			nitro pad.....	_____
			nicotine patch.....	_____
			internal pump.....	_____
			removable dentures.....	_____
			prostheses – joint, eyes, ears, penis.....	_____

OTHER IMPLANTS: _____

Your signature **Date today**

Print name as it appears on your insurance card. Note if insurance card is incorrect

Technologist: _____ **Date:** _____