

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.)..... | ___ | ___ | neurostimulator..... | ___ | ___ |
| Metal plates or screws..... | ___ | ___ | nitro pad..... | ___ | ___ |
| Cochlear implants..... | ___ | ___ | nicotine patch..... | ___ | ___ |
| Joint replacement..... | ___ | ___ | internal pump..... | ___ | ___ |
| Heart valve or previous..... | ___ | ___ | removable dentures..... | ___ | ___ |
| heart surgery | | | 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:** _____