ColumbiaDoctors | *Radiology*

212-326-8518
www.columbiaradiology.org

Patient Questionnaire

Print Name: _____ **Date of Birth:** _____

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.

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: _____

Has a health care provider informed you that you have abnormal kidney function, or are you aware of any kidney disease that you have? YES ☐ NO ☐

Are you or could you be pregnant? YES ☐ NO ☐
Inform the technologist if you are or think you are pregnant.
Are you Breast Feeding? YES ☐ NO ☐

_____ _____
Your signature **Date today**

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

Technologist:_____ **Date:**_____