CHEST/ABDOMEN/PELVIS CT/MR QUESTIONNAIRE

Date:_____

Name_____DOB_____AGE_____

What complaints or symptoms led you to see your doctor?_____

_____

Have you had surgery for any of the following?

	YES	NO	What type?
CHEST/LUNG/HEART	_____	_____	_____
LIVER	_____	_____	_____
SPLEEN	_____	_____	_____
KIDNEY	_____	_____	_____
COLON/BOWEL	_____	_____	_____
ULCER	_____	_____	_____
APPENDIX	_____	_____	_____
GALLBLADDER	_____	_____	_____
HYSTERECTOMY	_____	_____	_____
OVARIES	_____	_____	_____
PROSTATE	_____	_____	_____
COLOSTOMY	_____	_____	_____
HERNIA	_____	_____	_____
OTHER	_____	_____	_____

Please list any other medical problems that you have, or have had in the past.

_____

_____:

_____

Please list any and all medications you are currently taking.

_____

_____

_____

Patient's Signature_____