CHEST/ABDOMEN EVALUATION

Last Name:	First:	Date:

THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY

1. What was your chief complaint when you visited your doctor?_____

2. How long have you had these symptoms?_____

3. Have you had any bowel or bladder changes? Yes or No (Circle one)

4. Any surgery/arthroscopy on your abdomen or pelvis? Yes or No (Circle one) When? _____
   What was done in surgery? _____

5. Have you had an MRI, CT or Ultrasound of your abdomen or pelvis previously? Yes or No (circle one)
   If so, where and when? _____
   What were the results?_____

6. Do you have any other medical conditions? Yes or No (Circle one) List conditions:_____

10. Have you ever had cancer? Yes or No (Circle one) If yes, what type?_____
    Have you undergone chemotherapy, radiation therapy or surgery for cancer? Yes or No (Circle one)
    If yes, what type of cancer treatment have you had?_____
    Dates of cancer treatments:_____

11. Have you had an injury/trauma to the area being scanned today? (e.g. car accident, fall, etc.) Yes or No (Circle one) If yes, date of injury/trauma_____

12. Is there any other information about the area being scanned today that the radiologist should know about?_____

Please fill out back of this form