tollgateradiology.com *401.738.3100*

DIAGNOSTIC CLINICAL QUESTIONNAIRE

NAME: ______________________________ DATE: ____________________

ALLERGIES: ____

1. Why has your doctor sent you for this test? Did he/she give you a specific diagnosis?

____
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____
____

2. Please describe what specific complaints/symptoms have been most bothersome to you?

____
____
____

3. How long have you had these complaints/symptoms? ____________________

4. Do you have a history of cancer? If so, what type? ____________________

5. Have you had any previous surgery?:

Date	Type
__________	______________________________
__________	______________________________
__________	______________________________

6. Have you had any prior tests?

MRI	Date: __________	Place: ____________________
CT scan	Date: __________	Place: ____________________
Ultrasound	Date: __________	Place: ____________________
Nuclear Medicine	Date: __________	Place: ____________________
PET scan	Date: __________	Place: ____________________

Other ____

7. Are you or could you be pregnant at this time? ☐ yes ☐ no

(if yes, please let the technologist or radiologist know before the exam)