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?

_____

_____

_____

_____

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)