

OUTPATIENT QUESTIONNAIRE/ASSESSMENT RADIOLOGY & MEDICAL IMAGING DEPARTMENT

Patient Information and History

Name: _____ Date of Birth: _____ Today's Date: _____

Ordering Physician: _____

Exam(s) being done today: _____

Briefly explain to the best of your knowledge the reason for this exam: _____

What is the primary language spoken? _____

- 1. Do you need assistance walking and/or standing? Yes No
- 2. Are you "at risk" of falling? Yes No
- 3. Have you had any recent falls? Yes No

Date of recent fall: _____ Briefly explain: _____

- 4. Is there anyone with you today? Yes No
- 5. Do you have any known allergies to latex products? Yes No
- 6. Are you allergic to any medications? Yes No
If yes, what type(s)?: _____
- 7. Are you diabetic? Yes No

X-Ray, CT and Ultrasound patients:

- 8. Have you had any chemotherapy? Yes No
- 9. Have you had any radiation therapy? Yes No
- 10. Have you had any type of cancer? Yes No

Type of cancer: _____ Date Diagnosed: _____

11. Please list all surgical procedures: _____

12. Have you had any previous imaging studies? Yes No *If yes, please indicate below:

<u>Type of Study</u>	<u>Date</u>	<u>Facility</u>
Radiograph (X-Rays)	_____	_____
Computed Tomography (CT Scan)	_____	_____
Nuclear Medicine (Bone Scan)	_____	_____
MRI (Magnetic Resonance Imaging)	_____	_____
Ultrasound (Sonogram)	_____	_____
Other	_____	_____

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS



51221 (Rev. 06/09)

**OUTPATIENT QUESTIONNAIRE
& ASSESSMENT**

RAD-024

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Individualized Patient Care

1. What is one thing I can do for you to make sure you receive **very good** care today?

2. Are there any **special needs/considerations** that we should know about?

Medication List

Please list all medications you are currently taking:

Date	Medication Name	Dose	Frequency

Patient / Patient Caregiver Signature

Date

Clinician Signature (i.e. Medical Assistant)

Date

Clinical Signature (i.e. Technologist)

Date

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