UNIVERSITY RADIOLOGY

SCHEDULING & INFORMATION
800-758-5545
www.universityradiology.com

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____

Date of Birth _____ Height _____ Weight _____ Date of Last Menstrual Period _____ ☐ N/A

Reason for exam _____

Do you have Asthma? ☐ Y ☐ N Are you allergic to: X-ray Dye? ☐ Y ☐ N MRI Dye? ☐ Y ☐ N Latex? ☐ Y ☐ N

Food or Drug Allergies? ☐ Y ☐ N If yes, describe _____

Do you have Diabetes? ☐ Y ☐ N Do you have Kidney Disease? ☐ Y ☐ N Number of alcoholic drinks per week? ____

Smoking History (please check one box):

Never Smoked ☐

Former Smoker ☐ When did you quit? _____

Current Smoker ☐ How many years have you smoked? _____ How many packs per day do you usually smoke? _____

Do you have or have you had cancer? ☐ Y ☐ N If yes, what type of cancer? _____

Have you had chemotherapy? ☐ Y ☐ N Radiation Therapy? ☐ Y ☐ N If yes, when? _____

Surgical History *(Please list surgeries and dates)*

Brain	Gallbladder	Ovaries
Sinus	Appendix	Uterus
Pacemaker	Spine	Other

Previous Studies *(Please list when and where you had the study)*

CT Scan ..... ☐ Y ☐ N _____

X-rays ..... ☐ Y ☐ N _____

MRI Scan ..... ☐ Y ☐ N _____

Ultrasound ..... ☐ Y ☐ N _____

Mammogram ..... ☐ Y ☐ N _____

Nuclear/PET Scan ..... ☐ Y ☐ N _____

Describe Health Conditions You May Have *(Please describe any known abnormalities or symptoms)*

Circulation (heart, high blood pressure, aneurysm, etc) ☐ Y _____ ☐ N

Digestive (esophagus, stomach, bowels, etc) ..... ☐ Y _____ ☐ N

Respiratory (breathing, emphysema, lungs, etc) ..... ☐ Y _____ ☐ N

Nervous System (seizure, stroke, hearing, vision, etc) ☐ Y _____ ☐ N

Spine/Back (herniated disk, etc) ..... ☐ Y _____ ☐ N

Skeletal System (joints, arthritis, etc) ..... ☐ Y _____ ☐ N

Urinary (kidneys, kidney stones, bladder, etc) ..... ☐ Y _____ ☐ N

GYN (ovaries, uterus, etc) ..... ☐ Y _____ ☐ N

Other conditions/symptoms ..... ☐ Y _____ ☐ N

Are you in pain ..... ☐ Y Rate your pain on 1-10 scale, where 10 is the worst pain _____ ☐ N

Current Medications *(Please list prescription and non-prescription medications)*

_____

_____

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