DDI
Distinguished Diagnostic Imaging P.C.

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Board Certified Radiologist

MRI • BONE DENSITOMETRY • X-RAY • ULTRASOUND • MAMMOGRAPHY • CT SCAN

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CT Evaluation Questionnaire

Patient's Name __________________________________ Date ___________

DDI Account # _________________ Type of Scan _______________________

1.	What was your chief complaint when you visited your doctor?
2.	What do you think caused your problem?
3.	When did your symptoms begin?
	Days _____ Weeks _____ Months _____ Years _____
4.	Describe your symptoms/pain and its location.
a.	Which body part/location? _____________________________________ Front _____ Back _____ Right Side _____ Left Side _____
b.	Do you hear any noise when you move this area (joint)? Does it lock on you? Is there limitation of motion, swelling cysts, masses?
c.	Have you had a fracture or dislocation in this area? If yes, when and where?
d.	Do you have any history of arthritis?
5.	Have you had weakness in that specific area?

Please continue to fill out questions on the back of this form.

6.	Have you had surgery in the area being scanned? Please include arthroscopy and biopsy. If yes, when and where?

7.	Are you taking any medication? No ___ Yes ___ If yes, please list them.
	1)__________________ 2) ___________________ 3) __________________ 4)__________________ 5) ___________________ 6) __________________

8.	Do you have any allergies?

9.	Have you been diagnosed with Cancer? If yes, please give detail.

10.	Have you ever had radiation therapy or chemotherapy? No _____ Yes ____ If yes, when and why?
	Date of last therapy ____-____-____ Date of next therapy ___-___-___

11.	Are you being treated for any other illnesses or conditions? Including TB or Sarcoid.

12.	Have you had previous studies of the area being scanned? No ___ Yes___ If yes, where? ____________________________________ Date ___-___-___
	X-Ray _____ CT _____ MRI_____ Ultra Sound____ Dexa _____

~~~~~~~~~~~~~~~~~~~~~~~~~~ Staff Only~~~~~~~~~~~~~~~~~~~~~~~~~

Patient's History:	

Techs. Notes:	
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