

a place for hope, health
and happiness

Angel Williamson

IMAGING CENTER

PET/CT • CT • MAMMOGRAPHY • BONE DENSITY • ULTRASOUND
LUNG CANCER SCREENING • CARDIAC SCORING

5120 Bayou Blvd., Suite 9
Pensacola, FL 32503
850.476.1161 Fax 850.476.3575

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Ft. Walton Beach, FL 32547
850.862.1161 Fax 850.863.2431

Date of Exam: ___ / ___ / ___
PATIENT ID #: _____

CT QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: ___ / ___ / ___ Sex: M F
REFERRING MD: _____

To help us provide you with better medical care, please complete all sections below. If you need help completing this form, please ask one of our staff members for assistance.

PREGNANT? () No () Yes () Not Sure
Important: If Pregnant, or not sure, CT exam should NOT be performed.

Reason for today's examination:

Mass:	() No	() Yes	Diarrhea:	() No	() Yes
Pain:	() No	() Yes	Bloody Stool:	() No	() Yes
Infection:	() No	() Yes	Blood in urine:	() No	() Yes
Fever:	() No	() Yes	Other: _____	() No	() Yes
Constipation:	() No	() Yes			

For each reason for today's exam, please describe in detail its location, how long you have had the problem, and the names of physicians involved :

Prior study(s):

Please list any prior CT , PET, MRI, X-ray, ultrasound or other imaging studies you have had for current problem:

<u>Date</u>	<u>Type of Exam</u>	<u>Where Performed</u>	<u>Films and report available for comparison</u>
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Risk Factors for Cancer:

Smoker:	() No	() Yes	How long: _____ years
Passive Smoker:	() No	() Yes	How long: _____ years
History of Cancer:	() No	() Yes	How long: _____ years
Family History of Cancer:			

How many family members: _____

Other Medical History:

Surgery:	() No	() Yes	Stroke:	() No	() Yes
Radiation:	() No	() Yes	Cancer:	() No	() Yes
Trauma:	() No	() Yes	Infection:	() No	() Yes
Congenital disease:	() No	() Yes	Other: _____	() No	() Yes

For each other medical problem you have now, or have had in the past, please describe in detail its location, how long the problem lasted, how it was treated, and names of physicians involved :

PHYSICIAN'S LIST

Please provide us with COMPLETE full names, phone and fax numbers to ensure that your doctors will receive a copy of your reports.

Primary care physicians: _____

Phone #: _____ **Fax#:** _____

Surgeons: _____

Phone #: _____ **Fax #:** _____

Oncologists: _____

Phone #: _____ **Fax #:** _____

Radiation Oncologists: _____

Phone #: _____ **Fax #:** _____

Other physicians to receive reports: _____

Phone #: _____ **Fax #:** _____

Other physicians to receive reports: _____

Phone #: _____ **Fax #:** _____

Other physicians to receive reports: _____

Phone#: _____ **Fax#:** _____

Other physicians to receive reports: _____

Phone#: _____ **Fax#:** _____

Other physicians to receive reports: _____

Phone#: _____ **Fax#:** _____

Other physicians to receive repots: _____

Phone#: _____ **Fax#:** _____