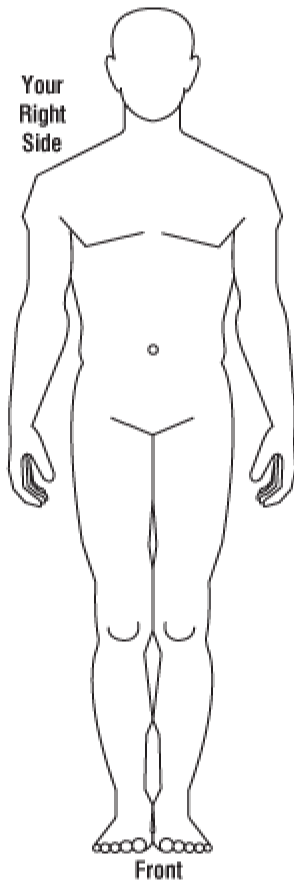
ASSOCIATED UROLOGICAL SPECIALISTS

## DIAGNOSTIC CENTER FORM

**Name:** ______________________________________________________ **Date:** ___________________

Please answer the following questions to the best of your ability. These are meant to assist our Radiologists as they interpret your exam.

Please shade in the area of your symptom and area(s) of concern on this diagram. You may chose more than one.




**Area(s) of Concern:**

Head

Neck

Chest

Abdomen

Pelvis

Spine

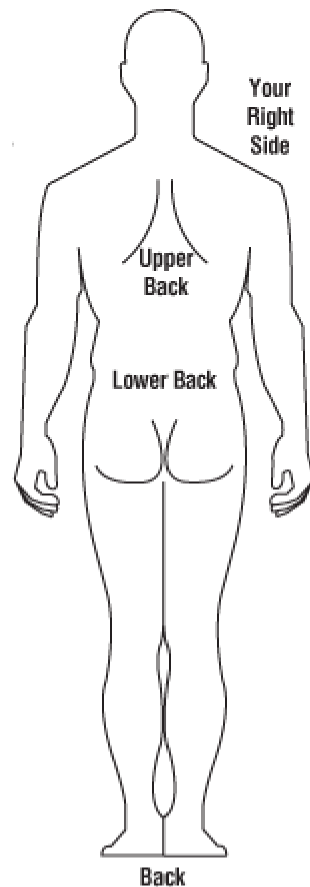
Arm

Elbow

Wrist/Hand

Hip/Leg/Knee

Foot/Ankle




Please describe your symptoms:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

When did this develop?_________________________________________________________________

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Do you have a history of cancer? ________________________________________________

Type of Treatment:______________________________________________________________

Have you ever had surgery on your chest, abdomen, or pelvis?____________________________

What type? _____________________________ How many years ago? _______________________

Did you ever had a CT Scan before?_______________________________________________

*Patients Screening for Contrast Injections*

1. Last menstruation period________________________ Hysterectomy ________________________

2. Last time you had anything to EAT ________________ Drink? ______________________________

3. Previous reactions to any contrast injection used in Radiology? Yes No

Type of Reaction? ____________________________________________________________

| | | |
|---|---|---|
| 4. History of Cardiac Problems: | Yes | No |
| a. Arrhythmias | Yes | No |
| b. Angina | Yes | No |
| c. Recent Heart Attack | Yes | No |
| 5. History of Allergies: | Yes | No |
| a. Drug | Yes | No |
| b. Asthma | Yes | No |
| c. Food | Yes | No |
| d. Hay fever | Yes | No |

6. History of Hypertension/High Blood Pressure/High Cholesterol: Yes No

| | | |
|---|---|---|
| 7. History of Seizures: | Yes | No |
| 8. History of Diabetes: | Yes | No |

List of Medications:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

_____________________________________________ ______________________

Patient Name Date