AUSTIN RADIOLOGICAL ASSOCIATION
PATIENT CONSULT QUESTIONNAIRE

Patient Name: _____ **Occupation:** _____

Date of Birth: _____

Past Medical History:

_____

_____

_____

Past Surgical History:

_____

_____

_____

Allergies (if so, explain reaction):

_____

_____

_____

Current Medications:

_____

_____

_____

Alcohol use: ☐ Yes ☐ No If yes, amount per week: _____ or per Month: _____

Tobacco use: ☐ Yes ☐ No If yes, amount per day: _____

General Health Questions *(Please indicate if you have any of the following):*

General:
- ☐ Yes ☐ No Fever
- ☐ Yes ☐ No Chills
- ☐ Yes ☐ No Recent weight change

Skin:
- ☐ Yes ☐ No Rashes
- ☐ Yes ☐ No Leg ulcers/sores
- ☐ Yes ☐ No Color change

Cardiovascular:
- ☐ Yes ☐ No Chest pain
- ☐ Yes ☐ No Heart palpitations
- ☐ Yes ☐ No Leg pain/swelling

Respiratory:
- ☐ Yes ☐ No Cough
- ☐ Yes ☐ No Shortness of breath

Ear, Nose, Throat:
- ☐ Yes ☐ No Ringing in ears
- ☐ Yes ☐ No Decreased hearing
- ☐ Yes ☐ No Runny Nose
- ☐ Yes ☐ No Watery Eyes
- ☐ Yes ☐ No Sore throat

Hematology:
- ☐ Yes ☐ No Easy bruising
- ☐ Yes ☐ No Easy bleeding

Musculoskeletal:
- ☐ Yes ☐ No Muscle pain
- ☐ Yes ☐ No Joint pain

Neurological:
- ☐ Yes ☐ No Decreased sensation
- ☐ Yes ☐ No Seizures
- ☐ Yes ☐ No Weakness

Gastrointestinal:
- ☐ Yes ☐ No Abdomen pain
- ☐ Yes ☐ No Nausea
- ☐ Yes ☐ No Vomiting
- ☐ Yes ☐ No Diarrhea
- ☐ Yes ☐ No Constipation
- ☐ Yes ☐ No Bloody stools

Eyes:
- ☐ Yes ☐ No Vision change

_____

Patient Signature Date