

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