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:

_____

_____

_____

Circle one

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