SDMI STEINBERG DIAGNOSTIC

History Questionnaire
Advanced Oncologic and Body Imaging

Patient Information Patient Number ____________

First Name ____________ Last Name ____________ Age ________

Reason for your Exam *(please describe in detail)*

____

____

____

TECH NOTES: *(for internal use only)*

Contrast ____________

Sedation ____________

Glucose (PET) ____________

SYMPTOMS *(circle all that apply)*

Pain	Acute	Chronic
Mass	Acute	Chronic
Infection	Acute	Chronic

What is the exact location of your symptoms:

____

Have you ever had Renal Failure / Dialysis? YES NO

If Yes, when: ____________

SYMPTOMS, Continued *(circle all that apply)*

Do you have Diabetes? YES NO

If Yes: (circle one) Insulin Oral Medication

Are you a smoker? Current Past Never

Cigarettes? YES NO OTHER

If yes, how many years? ____________

WOMEN ONLY, please continue *(circle all that apply)*

Had a hysterectomy (uterus removed)? YES NO

Had ovaries removed? Right Left Both

Any Cancer Diagnosis and History: Date Diagnosed ____________

What type of cancer do you have? ____________

Location ____________

Current Status: Newly Diagnosed, When? ____________

Recurrence, When? ____________

Remission, How Long? ____________

Treatment: Surgery Date of Last Treatment? ____________

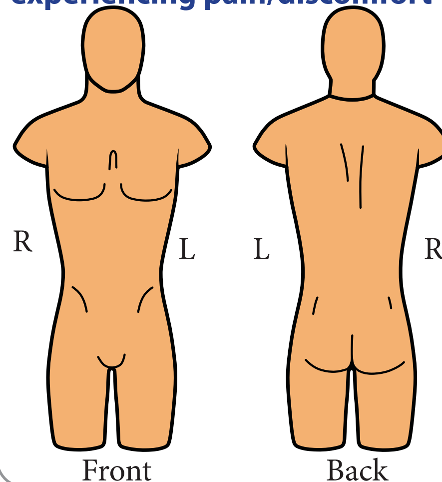
Radiation Date of Last Treatment? ____________

ChemoTherapy Date of Last Treatment? ____________

Has it spread? NO YES If Yes, Where ____________

Is your visit today related to this cancer diagnosis NO _____ YES _____

Please mark where you are experiencing pain/discomfort



Related Studies: Have you had a previous MRI, CT, or related Studies? ___ NO ___YES *(if yes continue below)*

Date of Study: ____________ Type of Study: ____________

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Previous surgeries, recent hospitalization, imaging studies and other important medical conditions

(Please list specifically, what and when. Use back if extra space needed.)

Procedure Description	Date