MEDICAL ARTS
RADIOLOGY
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SCREENING

MEDICAL/SURGICAL HISTORY

Bay Shore *Commack* *East Setauket* *Huntington*
Massapequa *Patchogue* *Plainview* *West Islip*

DATE _____

Describe your current symptoms:_____

_____

Why did your physician send you for this test?_____

_____

Describe any other conditions/diseases:_____

_____

Have you had prior surgery? Yes_____ No_____

If yes, describe briefly?_____

Do you have a history of cancer? Yes_____ No_____ (If yes complete this section)

When diagnosed and what type? _____

Have you received chemotherapy? Yes_____ No_____ If yes, when?_____

Have you received radiation therapy? Yes_____ No_____ If yes, when?_____

Have you had a recent injury? Yes_____ No_____

If yes, describe briefly the nature of your injury:_____

Place of injury (work, car accident, etc.)_____

Are you here for initial evaluation or follow-up?_____

Do you smoke? Yes_____ No_____QUIT?_____

Do you have pain? Yes_____ No_____

Where is the pain located?_____

What side is the pain? Left_____ Right _____

How long have you had pain?
_____ less than 1 week
_____ 1-4 weeks
_____ more than 4 weeks

How severe is pain?
_____ Minor (does not interfere with most activities)
_____Moderate (interferes with many activities)
_____ Severe (unable to engage in normal activities)

Patient Name_____ Signature_____