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PATIENT HISTORY
FLUOROSCOPIC & GASTROINTESTINAL STUDIES

Please complete the following to the best of your ability. If you are unsure how to answer, leave the space blank and we will assist with the answer when you are seen at our facility. All answers will be kept in strict confidence and treated as information in your medical record.

1. Your name: ______________________ Date: ____________

2. Date of Birth: ____________ Sex: [] Female [] Male MRN: _____

	Yes	No	
3.	[]	[]	Nausea
4.	[]	[]	Vomiting
5.	[]	[]	Constipation
6.	[]	[]	Diarrhea
7.	[]	[]	Diverticulitis
8.	[]	[]	Polyps
9.	[]	[]	Blood in stool
10.	[]	[]	Heartburn
11.	[]	[]	Difficulty swallowing
12.	[]	[]	Hernia
13.	[]	[]	Abdominal pain
14.	[]	[]	Crohns disease
15.	[]	[]	Have you had any of the following:

	Yes	No	
a.	[]	[]	Appendectomy
b.	[]	[]	Gallbladder removed
c.	[]	[]	Bowel resection (part?) ____________
d.	[]	[]	Colonoscopy When? ____________
e.	[]	[]	Endoscopy When? ____________
f.	[]	[]	History of cancer? What kind? ____________
g.	[]	[]	Other ____________

16. Do you have any general comments or questions about your health? ________

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MyDocuments\Forms\FluoroQuestionaire

No Potential For Pregnancy Exists
Date of LMP: ____________
Patient Signature: ____________
Technologist Signature: ____________
Fluoroscopic Time: ________ Dose: ________