Weinstein Imaging ASSOCIATES

Abdominal / Renal Questionnaire

Today's date _____ / _____ / _____ Birth date: _____ / _____ / _____ _____
month day year last 4 digits of SS#

Name _____ Age _____

Referring MD _____ 2nd MD to get report _____

Why has your MD ordered this exam? _____

Recent ultrasound, CT, MRI: Where? _____

When? _____ / _____ / _____ Results: _____

Do you have:	Latex allergy	YES	NO	
	Abdominal pain	YES	NO	
	Nausea/vomiting	YES	NO	
	Weight loss	YES	NO	
	Recent urinary tract infection	YES	NO	
	Recurrent urinary tract infection	YES	NO	
	Urinary frequency/urgency	YES	NO	
	Pain/burning with urination	YES	NO	
	Blood in urine	YES	NO	
Have you had:	Abnormal blood work	YES	NO	_____
	Abdominal/pelvic surgery	YES	NO	What type? _____
	History of cancer	YES	NO	What type? _____
	Hepatitis/liver disease	YES	NO	
	Kidney stones/disease	YES	NO	

MEN ONLY: Has your doctor noted any prostate enlargement? _____

WOMEN ONLY: First day of your last menstrual period _____ / _____ / _____

OR Postmenopausal _____ Had hysterectomy _____

ANY OTHER PERTINENT INFORMATION _____

_____