Guam Radiology Consultants

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Patient Questionnaire

Patient Name: Today's Date: _________________

Last First MI

1. Who is the doctor that referred you to this clinic? ___________________ Location: _________________
2. Do you have a follow-up appointment with the referring doctor? **Y** **N** If yes when? __________
3. Do you plan to see a specialist after this exam? **Y** **N** Specialist's Name: ____________________
4. Do you have a follow-up appointment with this specialist? **Y** **N** If yes when? _______________
5. Do you want a copy of your results faxed to the specialist? **Y** **N**
6. What did your physician instruct you to do after this exam? :

Explain:

Patient's Signature: ____Date: ___________________

FOR FEMALE PATIENTS:

ONLY IF YOU ARE GETTING AN X-RAY,BMD, OR A CT SCAN AND YOU ARE AGE 10 TO 60

1) ARE YOU PREGNANT? ☐ YES ☐ NO ☐ I DON'T KNOW. (**L**ast **M**enstrual **P**eriod) ____________________

2) IF NO, PLEASE WRITE "I AM NOT PREGNANT" IN THE SPACE BELOW:

____

3) IF YOU ARE 40YEARS OLD AND ABOVE, PLEASE INDICATE THE LAST TIME YOU HAD A MAMMOGRAM:

MONTH/YEAR_________________________ WHAT FACILITY? ______________________________

Patient's Signature: ____Date: ___________________

Parent or Guardian's Signature: _________________________________Date: ________________

VERIFED BY GRC STAFF: **Initial/EMP#**	**FOR FRONT DESK USE ONLY** **Referring Doctor**____ **Contact Number**____ **Patient Demographic Information Verified by:** ___________________

Revised: 02/28/2013 - hc