

Health History and Questionnaire

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of problem for which you’re being seen:**

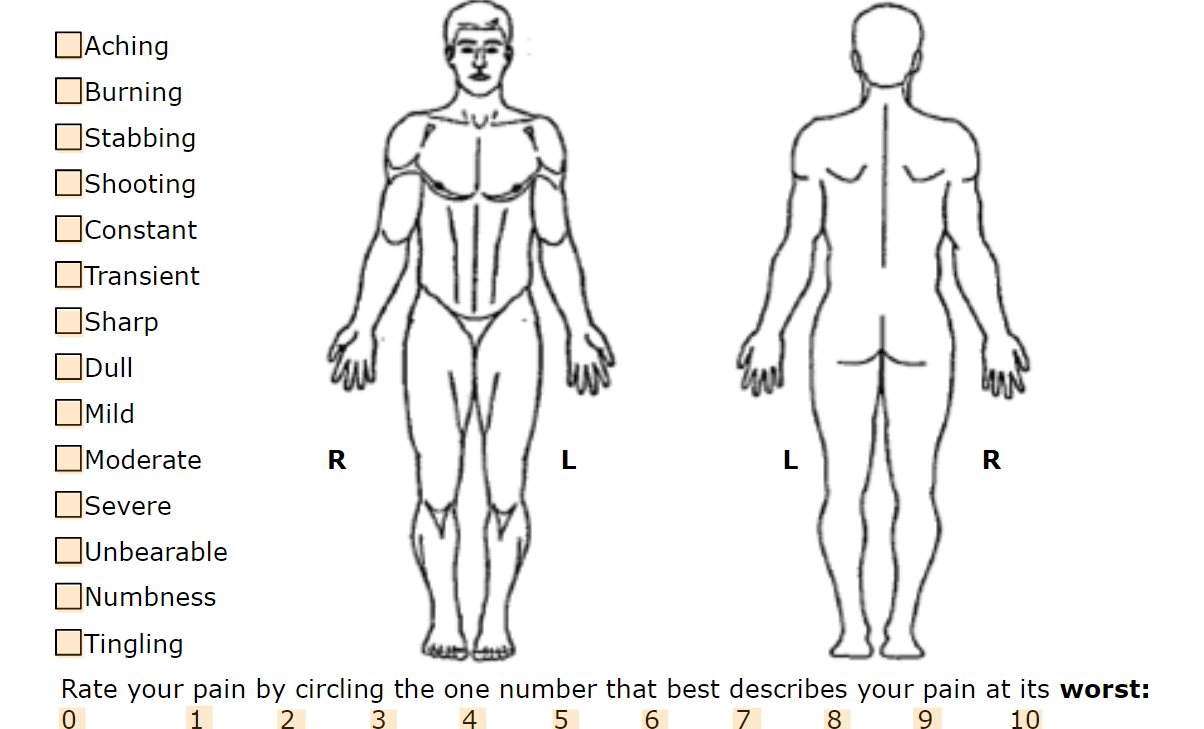
Reason for exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

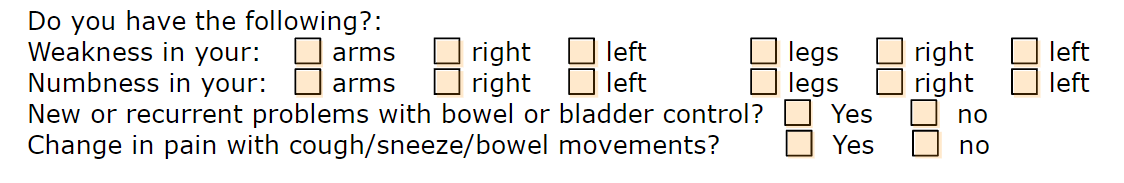
Type of injury:  Job  Accident  Sports injury  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have cancer?  Yes  No Cancer Type/Stage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On the diagram below put an “**x”** where it hurts the most; check all items that apply





**Prior imaging, check all items that apply:**



**PET**

Initial Staging YES NO

Subsequent Staging YES NO