Trinitas Diagnostic Imaging
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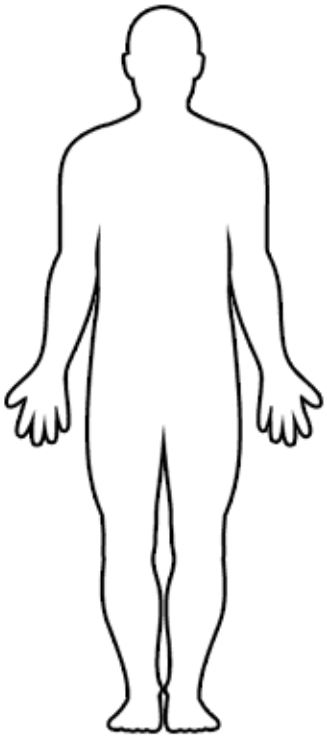
www.TrinitasDiagnosticImaging.com

Abdomen Questionnaire

If you're coming to our center for this test, print this page, fill out the form and bring it in with you on the day of your appointment.



Please circle the portion of your body that is in pain.

FIRST NAME

LAST NAME

AGE WEIGHT DATE

WHAT WAS YOUR CHIEF COMPLAINT WHEN YOU VISITED YOUR DOCTOR?

WHICH AREA IS AFFECTED?

☐ UPPER RIGHT SIDE ☐ UPPER LEFT SIDE
☐ LOWER RIGHT SIDE ☐ LOWER LEFT SIDE

ANY HISTORY OF CANCER? ☐ YES ☐ NO

IF YES, WHAT TYPE OF CANCER?

HOW LONG HAVE YOU HAD THIS PROBLEM?

ANY SURGERY OF THE ABDOMEN? ☐ YES ☐ NO

(A) IF YES, WHEN?:

(B) IF YES, WHAT WAS DONE?:

ANY OTHER MEDICAL CONDITIONS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN:

DESCRIBE YOUR GENERAL HEALTH:

HAS YOUR GALLBLADDER BEEN REMOVED? ☐ YES ☐ NO