

MRI*CT SCAN*ULTRASOUND*DIAGNOSTIC RADIOLOGY
CLINICAL INFORMATION
UPPER G.I. / SMALL BOWEL SERIES / BARIUM ENEMA

PATIENT

NAME: _____ DATE: _____

1. WHY ARE YOU HAVING THIS TEST? _____

2. DO YOU HAVE ABDOMINAL PAIN? _____ WHERE? _____

IS THE PAIN RELATED TO CERTAIN FOODS? _____ WHICH? _____

DOES THE PAIN WAKE YOU UP AT NIGHT? _____

IS IT BURNING? _____ KNIFELIKE? _____ GNAWING? _____

DISCOMFORT? _____ OTHER PLEASE LIST: _____

VOMITING? _____ BLOOD? _____ PRIOR ULCER? _____

DO YOU FEEL LIKE FOOD GETS CAUGHT IN YOUR THROAT? _____

DIARRHEA? _____ CONSTIPATION? _____

RECTAL BLEEDING? _____ BRIGHT: _____ RED: _____ DARK: _____

WEIGHT LOSS? _____ HAVE YOU HAD YOU APPENDIX REMOVED? _____

PRIOR SURGERY? _____ IF YES WHAT? _____

3. DID THE DOCTOR FEEL A MASS OR LUMP? _____ WHERE? _____

4. HAVE YOU HAD PREVIOUS CT SCANS, MRI'S, SONOGRAMS OR OTHER TESTS WHICH
MAY HELP INTERPRET THIS EXAM? _____

WHAT? _____ WHERE? _____

OTHER INFORMATION YOU FEEL MAY HELP: _____