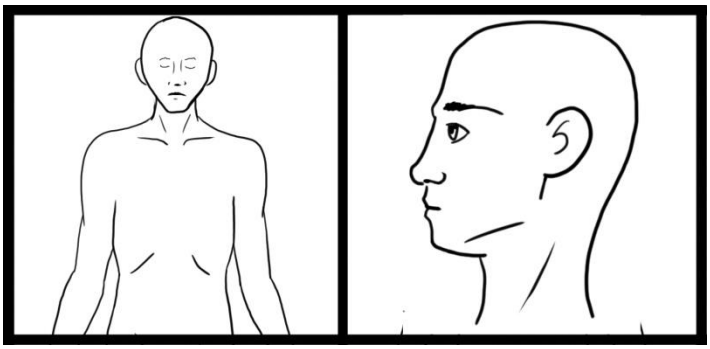
Patient Name: _____ Previous exam: _____
Date of birth: _____ Patient pregnant: YES NO
Medical Record #: _____ Patient breastfeeding: YES NO

Radiology Associates of the Fox Valley
333 N. Commercial Street, Neenah, WI

Swallowing

Please mark the location of any pain:



How long have you had your symptoms?
Have you had prior surgery done on your abdomen? If so, please tell us the approximate date(s) and procedure(s):
Please check if you have any of the following:

	Difficulty swallowing.
	Choking when swallowing.
	Food getting stuck in the throat.
	Food getting stuck in the lower esophagus.
	Regurgitation of chewed but undigested food.

If your pain was caused by trauma/injury, please describe how you were injured:

Please check any disease that you have had in the past or that you know you have now:

	pneumonia		Zenker's diverticulum
	esophagitis		congestive heart failure
	hiatal hernia		gastroesophageal reflux disease (GERD)
	cirrhosis of the liver		inflammatory bowel disease (including Crohn disease)

Have you ever been diagnosed with cancer? YES NO
If yes, what type? _____
If yes, have you ever had radiation therapy? YES NO If yes, when: _____

FOR TECHNOLOGIST USE ONLY (Fluoro time: ____ sec)

Call result?	No Yes	If "Yes", provider name/number:
Known follow-up appointment?	No Yes	If "Yes" indicate date/time and provider:
For CT and MR studies		
Was IV contrast injected?	No Yes	If "Yes": _____ mL of _____ (contrast type)
Was oral contrast given?	No Yes	If "Yes": _____ mL of _____ (contrast type)
Hydration protocol?	No Yes	If "Yes", provide details:
Patient premedicated for contrast?	No Yes	If "Yes", provide details:
Abnormal response to contrast?	No Yes	If "Yes", provide details: