XRAY QUESTIONNAIRE

Name:_____ **Date:**_____

Patient telephone number: _____

When is your next doctor's appointment?_____

Reason for exam today?_____

_____

_____

How long have you had the above mentioned symptoms?_____

List any surgeries in the area being examined today_____

_____

Medical History: (circle all that apply)

Diabetes High Blood Pressure Asthma COPD Emphysema

Smoking (past or present) Heart Disease Cancer: Type_____

Is this a workers comp injury? Yes No Is this a result of an auto accident? Yes No

If yes what is the date of injury: _____

Females only: Are you or could you be pregnant?_____

Have you had prior imaging of the area being imaged today?_____

Where:_____ **When:**_____

Additional Tech Notes:_____

_____

_____

_____

Referring Clinician: Telephone number: