

### X-Ray Information Sheet

Patient Name:	Date of Birth:	Age:
Weight:		

When is your next appointment with your physician to discuss the results of this study?		
What are your current symptoms?		
Have you had any previous surgery on the body part being imaged?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Explain:
Have you had any previous imaging studies of body part being imaged?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, list type of study and date:
Have you had any injury related to body part being imaged?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Injury:
Do you have any history of cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, what type?
Do you have any pain in body part being imaged?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Explain:
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last Menstrual Period:

Do you have or have you had any of the following:		
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Productive Cough
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fever	
<input type="checkbox"/> Chest Pain	Location of chest pain:	
<input type="checkbox"/> Current Smoker	<input type="checkbox"/> History of smoking in the past	
How many packs per day?	How many years have you smoked?	
<input type="checkbox"/> Other	Explain:	

Chest X-Ray Patients Only	
Is this a Pre-Operative Exam?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Surgery:	
Type of Surgery	

Current Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Patient Signature: \_\_\_\_\_