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?	❑ Yes ❑ No	If Yes, Explain:
Have you had any previous imaging studies of body part being imaged?	❑ Yes ❑ No	If Yes, list type of study and date:
Have you had any injury related to body part being imaged?	❑ Yes ❑ No	Date of Injury:
Do you have any history of cancer?	❑ Yes ❑ No	If Yes, what type?
Do you have any pain in body part being imaged?	❑ Yes ❑ No	If Yes, Explain:
Are you pregnant?	❑ Yes ❑ No	Last Menstrual Period:

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

Chest X-Ray Patients Only	
Is this a Pre-Operative Exam?	❑ Yes ❑ No
Date of Surgery:	
Type of Surgery	

Current Medications: _____

Allergies: _____

Patient Signature: _____