

Xray History

Name: _____ DOB: _____ Height: _____ Weight: _____

Reason for the Exam: _____

Are these symptoms related to a trauma/injury? YES NO

Level of Pain (1-10): _____
(0 = No pain, 10 = Extreme pain)

Pertinent Medical History: _____

Pertinent Surgery History: _____

Cancer Type and Diagnosis Date: _____

Radiation YES NO

Chemotherapy YES NO

Did you have prior imaging for the area being scanned today? NO YES: Location: _____

Do you have any monitoring/pump devices? YES NO If YES, they will need to be removed prior to imaging.

Smoking Status? Current Never Former – years since quitting? _____

Current or Former: Total years smoked: _____ Packs per day: _____

FOR WOMEN ONLY:

Date of last menstrual period: _____
Is there any chance you may be pregnant? YES NO

Are you breast feeding YES NO
If YES, what trimester: 1 2 3

No known allergies

Allergies: _____

Medications: _____

Patient/Parent/Guardian Signature: _____ Date: _____

TECHNOLOGIST USE: Tech Initials: _____

[Type here]