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Advanced Medical Imaging

X-RAY SAFETY SCREENING & MEDICAL HISTORY QUESTIONNAIRE

Because of the presence of radiation, we must have an accurate medical and surgical history.

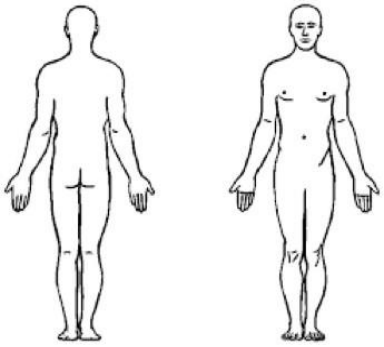
Patient Name:_____ Date of Birth:_____ Weight:_____

Please answer the following questions

Please describe your present complaint or problem:_____

What is the onset date of symptoms?_____

MARK THE LOCATION OF YOUR SYMPTOMS



Are you here as a result of
Car Accident ☐ **YES** ☐ **NO**
Work Accident ☐ **YES** ☐ **NO**
Other Accident ☐ **YES** ☐ **NO**

What is the date of the injury or accident?_____

Do you smoke? ☐ YES ☐ NO

Have you had previous imaging of the same part of your Body? ☐ YES ☐ NO

Where:_____ When:_____

Please check all diseases that you have had in the past or which you are now under treatment for:

_____High blood pressure _____(*) Cancer _____Diabetes _____Asthma

_____Heart Disease _____(*) Hereditary Disease _____Immune Deficiency

(*) Please Specify:_____

Any Possibility that you are pregnant? ☐ YES ☐ NO

Date of onset of Last Menstrual Period?_____ Hysterectomy_____ Birth Control _____
(date) (type)

_____ **(Initial)** To the best of my knowledge, I have no risk of pregnancy. If my last menstrual period has been greater than 4weeks, I understand I will be required to provide a urine sample for an HCG urine pregnancy test prior to my exam. This will be an additional $40.00 charge, to cover the cost of the test.

Patient or Guardian Signature: _____ Date: _____

FOR TECHNOLOGIST ONLY

Technologist Signature_____ Date:_____