LAKESIDE MRI & DIAGNOSTIC HEALTH

X-RAY QUESTIONNAIRE

NAME: _____, _____
(Last) (First)

HEIGHT: _____ WEIGHT: _____ lbs

MEDICAL HISTORY

WHY HAS YOUR PHYSICIAN SENT YOU FOR AN X-RAY? _____

ARE YOU EXPERIENCING PAIN OR OTHER SYMPTOMS? ☐ YES ☐ NO If yes, please list:

_____

HAVE YOU EXPERIENCED TRAUMA OR INJURY RECENTLY? ☐ YES ☐ NO If yes, please describe:

_____

ARE YOU BEING TREATED FOR ANY OTHER MEDICAL PROBLEM? ☐ YES ☐ NO If yes, please list:

_____

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER? ☐ YES ☐ NO If yes, please describe:

_____

HAVE YOU HAD ANY SURGERY? ☐ YES ☐ NO If yes, please list:

_____ DATE: _____

_____ DATE: _____

_____ DATE: _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ☐ YES ☐ NO If yes, please list:

_____

HAVE YOU EVER HAD A REACTION TO ANY CONTRAST MEDIA? ☐ YES ☐ NO

ARE YOU ALLERGIC TO IODINE? ☐ YES ☐ NO

HAVE YOU HAD ANY OTHER DIAGNOSTIC TESTS FOR THIS CONDITION? ☐ YES ☐ NO

WHERE?_____WHEN?_____WHAT KIND?_____

FEMALE PATIENTS ONLY

ARE YOU PREGNANT OR EXPERIENCING A LATE MENSTRUAL PERIOD? ☐ YES ☐ NO

ARE YOU CURRENTLY BREASTFEEDING? ☐ YES ☐ NO

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding this information.

_____ _____
Signature Date

TECH INITIALS: _____