



XRAY QUESTIONNAIRE

Name: _____ D.O.B. ____ / ____ / ____ Sex: M/F WT: _____ lbs.

Why are you having the exam? (Symptom): _____

What body part(s) are involved? (Side and Location): _____

How long have you had this problem? (Duration): _____

If due to injury, how did it occur? (Mechanism of Injury): _____

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

YES NO Do you have any underlying medical conditions which may be relevant to this exam?

YES NO Any prior imaging of the area? Where/when? _____

YES NO Any prior surgery of the area? Type/dates? _____

YES NO Do you have a history of being diagnosed with cancer? Type? _____

YES NO Any radiation therapy? If YES, dates? _____

YES NO Any chemotherapy? If YES, dates/type? _____

YES NO Do you now or have you ever smoked?

If YES, how many years did you smoke? _____ years

How many packs per day did you smoke? _____ packs per day

How long ago did you quit? If still smoking, mark as "0": _____ years ago

I acknowledge that all the information given is accurate and thereby consent to have X-ray examination performed on me.

Signature: _____ Date: ____ / ____ / ____

Technologist Notes: _____

Technologist Initials: _____

For Technologist Use Only () years

X () packs per day

() pack*years