X-RAY QUESTIONAIRE

NAME:____DATE:__________________

Please circle or fill in the following answers to these important questions, so that the physician can better interpret your exam. Thank you.

What is the **reason** for the test you are having today? List any symptoms that you are having (pain in a certain location, cough, shortness of breath, injury, etc.?) ___________

____

____

Do you have a history of any **major medical problems**? Yes No Please list:

____

____

Do you now or have you ever smoked cigarettes? Yes No _____packs/day for_____ years.

Have you had any **surgeries** performed in the area that we are examining? Yes No

Open heart gallbladder appendix thyroid hysterectomy (total partial) prostate bladder hernia bowel D+C tubal ligation mastectomy R L Lumpectomy R L liver kidney R L stent prosthesis C-section tonsils lymph node spinal surgery (neck lower back) level?________

Other:____

Have you ever had **cancer**? Yes No Type:_________________When:____________

Chemotherapy? Yes No **Radiation therapy**? Yes No

Any possibility that you may be pregnant? Yes No

Date of your last period_______________

TECH NOTES: