ADVANCED IMAGING CONCEPTS

RADIOLOGY GENERAL HISTORY FORM (X-RAY)

Patient Name: _____ Date: _____

Type of Study: _____ Weight: _____

Patients Age: _____ Smoker: Yes _____ or No _____

Any Personal History: COPD / ASTHMA or EMPHYSEMA (Circle any)

History of Personal Cancer: Yes or No (if yes list the type and year)

Are you allergic to Iodine (contrast)? Yes or No

List all drug allergies:_____

Tell us the symptoms for the test you are having today: _____

(Doctor order is not the answer)

Remove all jewelry and personal devices prior to being brought into exam room. You are responsible for your personal belongings.

Patient Signature Date

_____

Technologist Signature Date

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