X-Ray and Fluoro Questionnaire
Please answer all questions

Patient Name: ________________________________
Date: ________ Referring Doctor: ________________
Follow Up Appointment Date: ___________________

Female Patients
Are you Pregnant? ____________
Date of Last Menstrual Period: ________________

All Patients
List Medicines you are Allergic to: ________________
_____________________________________________

What symptoms are you having? ________________
_____________________________________________
_____________________________________________

Have you had an Injury related to today’s exam? ______
Date of Injury: ________________________________

What tests have you had relating to today’s exam? ______
_______________________________________________
_______________________________________________

Location of exam: ________________________________
Date of exam: ___________________________________

Signature _________________________ Date: ___/___/___