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:___/___/___