NORTH DOVER RADIOLOGY

X-RAY QUESTIONNAIRE

APPOINTMENT DATE_____**TIME**_____

Patient's Name _____ **DOB**_____ (**Circle)** Male/Female

Type of Scan_____R/O_____

Referring Physician _____ **Phone #**_____

Female Patients

Are you pregnant	☐ **YES** ☐ **NO** ☐ **N/A**
Date of last Menstrual Period	_____

ALL Patients

What symptoms are you having	
Have you had an Injury related to today's exam	☐ **YES** ☐ **NO** ☐ **N/A**
Have you ever had surgery to the related exam	☐ **YES** ☐ **NO** ☐ **N/A**
Do you have any prior report from any related exams	☐ **YES** ☐ **NO** ☐ **N/A**
Do you have any history of any cancer	☐ **YES** ☐ **NO** ☐ **N/A**
Do you have history of smoking	☐ **YES** ☐ **NO** ☐ **N/A**

Patient/Guardian Signature: _____ **Date:** _____

PATIENT: Please review the information provided at the time of scheduling. Your signature will verify its accuracy.