R·I·V·E·R Radiology

X-RAY TECHNOLOGIST INTERVIEW FORM

Patient's Name: _____

Age: _____ Weight: _____lbs. Sex: M or F

Are you Pregnant? Yes___ No___ Date of onset of Last Menstrual Period? _____

Are you here as a result of a **Car Accident? Yes___ No___**
Work Accident? Yes___ No___
Do you smoke? **Yes___ No___**

Please check all diseases that you have had in the past or for which you are now under treatment:

___High blood pressure ___ (*)Cancer ___Diabetes ___Asthma
___Heart Disease ___ (*)Hereditary Disease ___Immune Deficiency

(*)Please Specify: _____

Have you had previous X-rays or any other studies of the same part of your Body? _____

Where: _____When_____
(Name of Facility) (Date of Service)

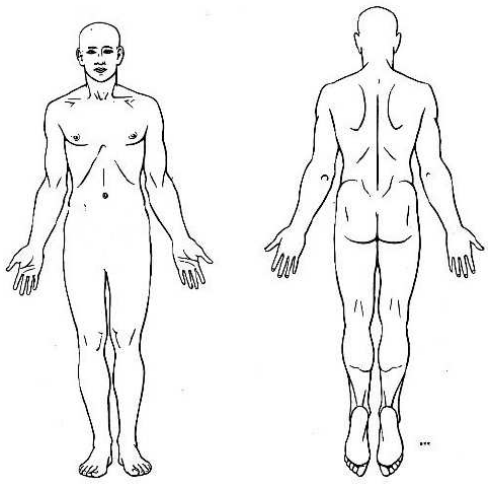
Please describe in your own words your present complaint or problem. How long ago did it start? What does your doctor think is the cause?

_____

_____

_____

PLEASE SHADE FIGURES TO INDICATE SPECIFIC AREAS OF PAIN OR DISCOMFORT



Script Dx: _____

Referring Physician: _____

Technologist Notes:

Patient's Signature: _____ Date: _____ Tech Review: _____