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## PRE-EXAM INTERVIEW

Please Complete to the Best of your Ability

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

WEIGHT \_\_\_\_\_ PHONE \_\_\_\_\_ LAST MENSTRUAL PERIOD \_\_\_\_\_

REASON FOR EXAM: \_\_\_\_\_  
 (symptoms)

REFERRING PHYSICIAN: \_\_\_\_\_

**MEDICAL HISTORY:**

	YES	NO	
1.			DIABETES
2.			MYELOMA (BONE CANCER)
3.			KIDNEY DISEASE
4.			LUNG PROBLEMS
5.			HIGH BLOOD PRESSURE and/or HEART PROBLEMS
6.			ALLERGIES (specify)
7.			TAKING MEDICATIONS (specify)
8.			PAST SURGERIES
9.			X-RAY PREP INSTRUCTIONS GIVEN
10.			TAKING MEDICATIONS (specify)

PATIENT SIGNATURE: \_\_\_\_\_

**FOR OFFICE USE ONLY**

X-RAY # \_\_\_\_\_ PROCEDURE \_\_\_\_\_

PREVIOUS CONTRAST STUDY Y N TIME: \_\_\_\_\_ DATE: \_\_\_\_\_

CONTRAST REACTION Y N HOW MANIFESTED? \_\_\_\_\_

EVALUATION: \_\_\_\_\_ ROUTINE \_\_\_\_\_ PROBLEM \_\_\_\_\_

ACTION TAKEN: \_\_\_\_\_

CONTRAST ADMINISTERED (NAME/DOSAGE) \_\_\_\_\_

TECHNOLOGIST SIGNATURE \_\_\_\_\_

RADIOLOGIST SIGNATURE \_\_\_\_\_