MedCross Imaging LLC

Xray Screening Form

Date_____

Last Name _____ **First Name** _____

DOB_____ **Age**_____ **Height**_____ **Weight**_____ (lbs) **Male / Female**

Please describe your symptoms/injury or reason for procedure? _____

_____

_____

_____

How long have you had these symptoms? _____

PREVIOUS MEDICAL HISTORY:

Is there any chance of pregnancy? □ Yes □ No

Are you a smoker? □ Yes □ No

Have you had any prior Surgeries? □ Yes □ No

If yes, please type of Surgery_____

_____

I understand the information presented to me and have answered all the questions to the best of my knowledge.

_____ _____ _____

Signature of person providing information Relationship to patient Date

(For Imaging Personnel Only)

Technologist Comments: _____

_____

_____

_____**Technologist**

Signature: _____ **Date:**_____