DIAGNOSTIC IMAGING ASSOCIATES

☐BRANDYWINE
☐OMEGA IMAGING
☐PIKE CREEK
☐GLASGOW

GENERAL RADIOLOGY

PATIENT #____________

PATIENT NAME:______________________________ AGE: ________M/F

TYPE OF STUDY:______________________________ DATE: ____________

REFERRING PHYSICIAN: ______________________________

REASONS FOR TEST: ______________________________

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PERTAINING TO TODAY'S STUDY

ANY PREVIOUS RADIOLOGY STUDIES? YES / NO

(a) When:______________________________

(b) Where Done: ______________________________

(c) Diagnosis (What was found)? ______________________________

ANY PREVIOUS CAT SCAN, MRI, ULTRASOUND OR NUCLEAR MEDICINE STUDIES? YES / NO

(a) When:______________________________

(b) Where Done: ______________________________

(c) Diagnosis (What was found)? ______________________________

ANY PREVIOUS SURGERY, CHEMO. OR RADIATION THERAPY? YES / NO

(a) When:______________________________

(b) Where Done: ______________________________

(c) Where on Body:______________________________

ANY PREVIOUS INJURIES? YES / NO

(a) When:______________________________

(b) Where on Body:______________________________

ANY PREVIOUS ILLNESS? YES / NO

(a) When:______________________________

(b) Where on Body:______________________________

DO YOU SMOKE? YES / NO

(a) How Long:______________________________

FEMALE PATIENT: Is there a chance of **PREGNANCY**? YES / NO

Date of Last Menstrual Period______________________________

SHIELDED YES____________NO______________

ALLERGY TO LATEX? YES / NO

TECHNOLOGIST:______________________________R.T.

REV 5/01FG