# X-RAY HISTORY FORM

**Patient Name:** _____ **MR#:** _____ **Today's Date:** _____

**DOB:** _____ **Age:** _____ **Referring Physician:** _____

**Female Patients Only:**

Date of last menstrual period: _____ Are you currently, or could you be pregnant? **YES** **NO**

Are you breast feeding? **YES** **NO** Are you postmenopausal? **YES** **NO**

**Reason for Exam:** _____

**Signs/Symptoms:** _____

**Duration of Symptoms:** _____

**Are symptoms due to an injury:** **YES** **NO**

**If yes to above, please explain:** _____

_____

_____

**Have you ever been diagnosed with cancer?** **YES** **NO**

**If yes, what kind of cancer?** _____

**Have you ever been diagnosed with arthritis?** **YES** **NO**

**If yes, what kind?** _____

**Have you had prior imaging exams related to your current symptoms:** **YES** **NO**

**If yes to the above: Exam Done:** _____ **Where:** _____

**CONSENT:** **I attest the above information is correct to the best of my knowledge. I have read and understand the content of this form. I have had the opportunity to ask questions regarding the information on this form.**

_____ _____

**Patient/Guardian Signature** **Date**

**3405 College Street, Beaumont, TX 77701 Phone: (409) 832-2211 Fax: (409) 434-4277**