Monticello Diagnostic Imaging
A Service of Wise Regional Health System

X-RAY HISTORY SHEET

Patient # _____ Patient Name _____ Date_____

Age _____ DOB ___/___/___ Height _____ Weight _____ Gender: M F

Reason for Exam:

_____

Location of Pain:

_____

How long have you had symptoms or pain?

_____

Medical History

Cancer Yes No Date of Diagnosis: _____
Type of Cancer: _____

Diabetes Yes No

High Blood Pressure Yes No

Smoking Yes No

Asthma Yes No

COPD Yes No

Have you had any major surgeries? Yes No
If yes, please explain:

_____

_____

Prior Studies

Have you had previous imaging studies of the body part being examined today? Yes No

Type of Exam:_____

Facility: _____

Date of Exam: _____

Patient Signature: _____ Date: _____