DENVILLE DIAGNOSTICS 973.586.1212 | RADIOLOGY CENTER OF FAIR LAWN 973.238.0700 | STAR MRI OF WAYNE 201.475.1300

IMAGECARE CENTERS

1.2T Open MRI · 1.5T Extremity MRI · 1.5T Short/Wide Bore MRI · MR/CT Angiography · Arthrograms
CT Scan · Ultrasound · X-Ray · 3D Mammography · Bone Density · Dental Scan

ULTRASOUND/X-RAY QUESTIONNAIRE

Please answer the following questions to the best of your ability. If you are unsure about any questions, please discuss them with your technologist. If you are here because you are or may be *pregnant*, please fill in the first line, and then skip to question #4. Thank you.

Name: _____ Date of Birth: _____

1. Please indicate the symptoms you currently have that are specific to your exam today:

(***circle all that apply)***

Headache/Ringing in Ears	Upper Back	Hand (right/left)
Vision Loss/Changes	Lower Back	Leg (right/left)
Dizziness	Neck	Knee (right/left)
Numbness in arms/legs	Shoulder (right/left)	Foot (right/left)
Chest	Arm (right/left)	Abdomen/Pelvis

Pain, lump or mass (location):_____ Other:_____

2. How long have you had these symptoms?_____

3. Is your condition the result of an injury? **Yes** **No**
Please describe:_____

4. Have you had any previous testing on the area being examined today? **Yes** **No**
Ultrasound (date): _____ X-Ray (date):_____ MRI (date):_____ CT (date):_____

5. Have you had surgery on the area being examined today? **Yes** **No**
Please describe:
_____

6. Have you ever been diagnosed with cancer or a serious medical condition? **Yes** **No**
Condition and location in your body:_____
Radiation or chemotherapy: Radiation Chemotherapy

7. Do you have any known allergies? **Yes** **No**_____

8. Are you presently taking medication on a daily basis? **Yes** **No**_____

9. For X-Ray patients, is there *any chance of pregnancy*? **Yes** **No**
Last Menstrual Period:_____

10. Is this due to an auto accident or workers compensation claim? **Yes** **No**

Reason for today's
exam:_____

Patient/Guardian
Signature:_____**Date:**_____