WASHINGTON RADIOLOGY

CLINICAL INFORMATION
GENERAL/CHEST X-RAY

ACCT # ____________________ Tech's Init./Exam Date ________/________

Patient's Name ______________________________ Referring Physician ______________________________

Date of Birth__________________ Age__________ Next Appointment with Referring Physician ______________________

TYPE OF EXAM ☐ PA Chest ☐ Complete Chest ☐ Abdominal, Flat ☐ Abdomen, Flat and Upright
☐ Skull ☐ Sinus ☐ Ribs ☐ C-Spine ☐ L-S Spine ☐ T-Spine
☐ Extremity (area) ______________________________
☐ Other ______________________________

Why are you having this examination (medical problem) including symptoms? ____________________

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List other imaging studies you have had/will have regarding this problem and where they were performed (if applicable):

☐ CT ____________________ ☐ X-ray ____________________ ☐ Ultrasound____________________
☐ MRI ____________________ ☐ Nuclear Medicine/PET ____________ ☐ Other____________________

What were the results? ______________________________

Did you bring a copy of the results and films? ______________________________

History and dates of prior surgeries of this area: ______________________________

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Do you have a personal or family history of cancer? ☐ Yes ☐ No

If yes, please explain. ______________________________

CHILDBEARING WOMEN ONLY Date of last menstrual period____________________

Are you possibly pregnant? ☐ Yes ☐ No Patient's Signature______________________________ Date__________
(If yes, notify technologist immediately)

FOR CHEST X-RAY PATIENTS ONLY

Please check any of the following symptoms you may be experiencing:

☐ Cough ☐ Wheezing ☐ Chest Pain ☐ Shortness of Breath ☐ No Symptoms
☐ Fever ☐ Recent Foreign Travel ☐ Other ______________________________

Comments: ______________________________

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Have you had a previous chest x-ray? ☐ Yes ☐ No

If yes, when?__________________ Where? ______________________________

Please circle appropriate answer: Smoker Ex-Smoker Non-Smoker

YOUR INSURANCE COMPANY MAY OR MAY NOT REIMBURSE FOR ROUTINE X-RAYS.
I understand that I am responsible for full payment if my insurance company does not pay.

______________________________ ____________________
Patient's Signature Date