



# X-RAY TECHNOLOGIST INTERVIEW FORM

Patient's Name: \_\_\_\_\_

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. Sex: M or F

Are you Pregnant? Yes \_\_\_ No \_\_\_ Date of onset of Last Menstrual Period? \_\_\_\_\_

Are you here as a result of a **Car Accident?** Yes \_\_\_ No \_\_\_

**Work Accident?** Yes \_\_\_ No \_\_\_

Do you smoke? Yes \_\_\_ No \_\_\_

Please check all diseases that you have had in the past or for which you are now under treatment:

\_\_\_ High blood pressure    \_\_\_ (\*)Cancer    \_\_\_ Diabetes    \_\_\_ Asthma  
\_\_\_ Heart Disease    \_\_\_ (\*)Hereditary Disease    \_\_\_ Immune Deficiency

(\*)Please Specify: \_\_\_\_\_

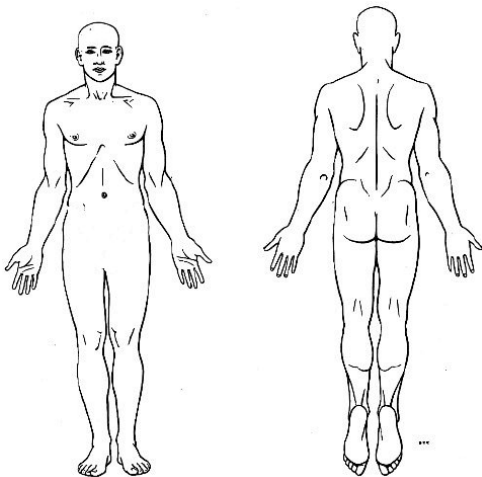
**Have you had previous X-rays or any other studies of the same part of your Body?** \_\_\_\_\_

Where: \_\_\_\_\_ When \_\_\_\_\_  
(Name of Facility) (Date of Service)

Please describe in your own words your present complaint or problem. How long ago did it start? What does your doctor think is the cause?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE SHADE FIGURES TO INDICATE SPECIFIC AREAS OF PAIN OR DISCOMFORT**



Script Dx: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Technologist Notes:

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Tech Review: \_\_\_\_\_