Patient History/Intake Form

Instructions: Please provide information in sections 1, 2 & 3 prior to seeing the technologist *(check all that apply)*

1 **Patient Name:** _____ **Date of Birth:** _____

* **Female Patients:**
Is there any possibility you are pregnant? ☐ Yes ☐ No Signature: _____

2 **Prior Medical Imaging**

Have you had recent x-rays of the same body part(s)?

☐ Yes
When? _____

Where? _____

☐ No

On the skeleton below: Mark the body part(s) we are x-raying today

3 **Check All That Apply and Briefly Explain**

Reason for exam today: _____

☐ **Trauma/Injury?** ☐ Yes ☐ No
Date of Trauma: _____
Brief Description: _____

☐ **Pain,**
Where? _____
For how long has it hurt? _____
Does it hurt now? ☐ Yes ☐ No
...All the time? ☐ Yes ☐ No
...Occasionally? ☐ Yes ☐ No

☐ **Pre-Surgery,**
Date of Surgery: _____

☐ **After Surgery,**
Date of Surgery: _____

☐ **Arthritis**
Osteoarthritis? ☐ Yes ☐ No
Rheumatoid? ☐ Yes ☐ No
Juvenile? ☐ Yes ☐ No
Lupus? ☐ Yes ☐ No
Other? _____

☐ **Hereditary/ Congenital Condition:** _____

☐ **Other:** _____

Technologists Only

Area of Interest:	Right	Left	Anterior	Posterior	Medial	Lateral	Notes/Specific Digits/Details
☐ Hip(s)	☐	☐	☐	☐	☐	☐	
☐ Pelvis	☐	☐	☐	☐	☐	☐	
☐ Knee(s)	☐	☐	☐	☐	☐	☐	
☐ Hand(s)	☐	☐	☐	☐	☐	☐	
☐ Foot /Feet	☐	☐	☐	☐	☐	☐	
☐ Upper Extremity	☐	☐	☐	☐	☐	☐	
☐ Lower Extremity	☐	☐	☐	☐	☐	☐	

☐ Spine ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Sacral

☐ Other: _____

Comments: _____

Date of exam: _____ Tech Initials: _____ Supervisor initials: _____