



Rockledge MRI & PET Imaging Center

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X-Ray Clinical

Name _____ Patient # _____

Previous surgery on area of scan? YES / NO If yes, what type? _____

Previous trauma/accident? YES / NO Duration? _____ Type of injury? _____

Have you ever been diagnosed with cancer? YES / NO Type _____ Year _____

Body Part _____ Treatment SURGERY / RADIATION / CHEMO THERAPY

Are you allergic to latex? YES / NO _____

Are you pregnant? YES / NO _____

Are you breastfeeding? YES / NO _____

PRIOR STUDIES:

Scan Type: _____ Area _____ Facility _____ Date _____

Scan Type: _____ Area _____ Facility _____ Date _____

Scan Type: _____ Area _____ Facility _____ Date _____

Staff Initial _____

Patient's Signature _____

Date _____