Rockledge MRI and PET Imaging Center
1910 Rockledge Blvd Ste 102
Rockledge, FL 32955
321.636.6599T 321.636.6614F

X-RAY/ULTRASOUND CLINICAL INFORMATION

Patient Name_____ Patient MRN:_____

Height_____ Weight_____

Prior surgery on area we are imaging today? YES/NO If YES, what type?_____

Prior trauma or accident involving area we are imaging today? YES/NO Type of injury_____

Prior diagnosis of cancer? YES/NO Type:_____Year diagnosed:_____

Body region of cancer:_____

Treatment: SURGERY / RADIATION / CHEMOTHERAPY

Females:

Are you pregnant? YES/NO
Are you breast feeding? YES/NO

Patients:

Allergies:_____

Ultrasound Patients:

Last time ate or drank anything:_____

Consume_____of water_____prior to exam STAFF INITIAL_____

Have you had any prior imaging of the area we are examining today?

_____

_____

If YES, please indicate type of exam, what area it covered, what facility it was performed at and the approximate date.

Patient's Signature_____ Date Signed_____