Princeton Radiology
Excellence in Imaging

XRAY QUESTIONNAIRE

Name:_____ D.O.B.___/___/____ Sex: M/F WT:_____lbs.

☐ YES NO ☐ Have you received a COVID vaccine? If yes, please answer the following:
Pfizer/Moderna/J&J 1st dose date: _____ Arm: R/L 2nd dose date: _____ Arm: R/L

Why are you having the exam? (Symptom):_____

What body part(s) are involved? (Side and Location):_____

How long have you had this problem? (Duration):_____

If due to injury, how did it occur? (Mechanism of Injury):_____

☐ YES NO ☐ Is there any chance you may be pregnant? Date of last menstrual period?_____

☐ YES NO ☐ Do you have any underlying medical conditions which may be relevant to this exam?

☐ YES NO ☐ Did you have any prior imaging of the area being scanned in another imaging facility?
If YES, where/when? _____

☐ YES NO ☐ Any prior surgery of the area? Type/dates?_____

☐ YES NO ☐ Do you have a history of being diagnosed with cancer? Type?_____

☐ YES NO ☐ Any radiation therapy? If YES, dates?_____

☐ YES NO ☐ Any chemotherapy? If YES, dates/type?_____

☐ YES NO ☐ Do you currently have an inferior vena cava (IVC) filter placed in your body?

☐ YES NO ☐ If yes above, is there a plan in place to remove the filter?

☐ YES NO ☐ Do you now or have you ever smoked?

If YES, how many years did you smoke? _____ years

How many packs per day did you smoke? _____ packs per day

How long ago did you quit? If still smoking, mark as "0": _____ years ago

I acknowledge that all the information given is accurate and thereby consent to have X-ray examination performed on me.

Signature:_____ Date:___/___/___

Technologist Notes:_____

_____

Technologist Initials:_____

For Technologist Use Only ( ) years

X ( ) packs per day

( ) pack*years