



**ASSOCIATED RADIOLOGISTS
HISTORY SHEET FEMALE PATIENT**

NAME _____ DATE _____ D.O.B _____

ADDRESS _____ CITY _____ ZIP _____

NAME OF DOCTOR ORDERING EXAM: _____

NAME OF OTHER DR. TO RECEIVE A REPORT: _____

WHAT EXAM (S) ARE YOU HAVING? _____

IN CASE OF AN EMERGENCY NOTIFY: _____ PHONE NUMBER: _____

REASON FOR EXAM? ___ COUGH ___ FEVER ___ SHORTNESS OF BREATH

___ PAIN-LOCATION _____ HOW LONG? _____

___ INJURY-LOCATION _____ WHEN? _____

OTHER _____

MEDICAL HISTORY:

___ DIABETES ___ HIGH BLOOD PRESSURE ___ SMOKING ___ ASTHMA

OTHER _____

___ KIDNEY PROBLEMS HAVE YOU BEEN ON DIALYSIS? ___ YES ___ NO

DO YOU HAVE ANY ALLERGIES? ___ YES ___ NO

LIST ALLERGIES: _____

PREVIOUS SURGERY (PLACES AND DATES) _____

POSSIBILITY OF PREGNANCY? YES ___ NO ___ LAST MENSTRUAL PERIOD _____

PREVIOUS SIMILAR OR RELATED XRAY STUDIES:

STUDY _____ WHERE? _____ DATE _____

STUDY _____ WHERE? _____ DATE _____

STUDY _____ WHERE? _____ DATE _____

PATIENTS SIGNATURE _____ DATE _____

If signed by patient's representative, state relationship _____

MRN _____ ACC # _____