

HOBOKEN RADIOLOGY

Providing a clearer image of health

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X-RAY QUESTIONNAIRE

MR# _____

OFFICE USE ONLY

Patient Name: _____

D.O.B.: ____ / ____ / ____ Sex: MALE FEMALE

Why are you having this exam done? _____

ARE YOU PREGNANT OR POSSIBLY PREGNANT? YES NO

Which medical illnesses do you have? _____

Please list all previous surgeries? _____

PATIENT SIGNATURE: _____ DATE: _____

TECHNOLOGIST: _____ DATE: _____