Denver Integrated Imaging

X-Ray Examination Sheet

Today's Date: _____

Name: _____

Date of Birth: _____

Patient Summary:

Type of X-Ray: _____
What do you think caused this problem for which you are here today?
_____
_____
_____
_____
____
Do you have numbness? Yes _____ No _____ Where? _____
Do you have weakness? Yes _____ No _____ Where? _____
Does your pain go down your arms? Yes _____ No _____
Does you pain go down your legs? Yes _____ No _____
Have you had any bladder or bowel changes? Yes _____ No _____ If yes, please explain:
_____
_____
_____
___
What is your height? _____
What is your Weight? _____lbs

For women only:

Is there any possibility that you may be pregnant? Yes _____ No _____
Date of you last menstrual period: _____

Release of Responsibility

I release Denver Integrated Imaging South of all responsibility in connection with possible pregnancy with respect to any examination ordered by my physician.

Patient Signature: _____

Date: _____

Witness Signature: _____