ASSOCIATION OF ALEXANDRIA RADIOLOGISTS, PC

❑ *Alexandria Imaging Center*
❑ *Woodbridge Imaging Center*

Dear Patient,

In an effort to provide a more complete history for the radiologist reviewing your exam, please take a moment to answer the following questions:

Why did your doctor send you for this test?

_____

_____

Are you here as a result of an injury? **Yes** **No**

If yes, what kind of injury?_____

Please provide the date of your injury_____

Is your injury the result of an auto accident? **Yes** **No**

Is your injury work related? **Yes** **No**

Do you have pain? **Yes** **No**

If yes, where is the pain? _____

How long have you had the pain? _____

Do you have a cough? **Yes** **No**

Do you have a fever? **Yes** **No**

Are there any other health symptoms, conditions or reasons for this test we should be aware of? _____

_____

_____
Print Name

_____ _____
Signature **Date**

Thank you for completing this form.