Rockledge MRI & PET Center

1910 Rockledge Blvd. Suite 102, Rockledge, FL 32955
P (321) 636-6599 F (321) 636-6614

X-RAY/ULTRASOUND CLINICAL

Patient Name____ Patient #________________

When is your follow up appt with Dr.?____

Previous surgery on area of scan? YES/NO If yes, what type? _________________________________

Previous trauma/Accident? YES/NO Duration? __________ Type of injury?___________________

Have you ever been diagnosed with cancer? YES/NO Type___________________ Year_______________

Body Part____________________________ Treatment SURGERY / RADIATION / CHEMO THERAPY

Are you pregnant? YES/NO _________________________________
Are you breastfeeding? YES/NO _________________________________
Are you allergic to latex? YES/NO _________________________________
Are you taking any medications? YES/NO _________________________________

NPO__________

Consume ________of water ________prior to exam STAFF INITIAL__________________

PRIOR STUDIES
:

Scan Type_________ Area________________ Facility____________________ Date_________
Scan Type_________ Area________________ Facility____________________ Date_________
Scan Type_________ Area________________ Facility____________________ Date_________

Patient's Signature____Date___________________