ROSEVILLE
DIAGNOSTIC IMAGING

X-RAY

IMPORTANT WARNING

YES	NO	
❑	❑	Have you had a Cough, Fever, or any Flu-like symptoms within the past 2 weeks?
❑	❑	Have you recently come into contact with anyone who was COVID positive?
❑	❑	Any recent travels outside of the USA?

Are you pregnant? ❑YES ❑NO

Have you had an X-ray before? ❑YES ❑NO
If YES: When: _____ Where: _____What type: _____

Are you Allergic to any medication or Radiology dye (contrast)? ❑YES ❑NO

Why are you having this X-ray? _____
_____

Is this a result of an injury? ❑YES ❑NO Type of injury: _____When:_____

Any pain? For how long? _____

Any prior surgeries? _____

I attest that the above information provided by me is correct to the best of my knowledge. I have read and understood the entire content of this form and I have had the opportunity to ask any unclear issue in this regard.

Print Name: _____

►Signature: _____Date: _____/_____/_____

RDI Reception: _____X-ray Technologist:_____

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