

FLUOROSCOPY
Valley Imaging Center

Please Print

Patient ID#: _____

Exam: _____ Date: _____

Patient Name: _____ Age: _____ Sex: Male Female

DOB: _____ Weight: _____ Height: _____

Home Phone #: _____ Cell Phone #: _____

What are your symptoms/complaints? _____

How long have you had these symptoms? _____

Have you had any surgeries? _____ If yes, list: _____

Do you have a history of any of the following?

Hiatal Hernia	Yes	No	Renal Problems	Yes	No
Ulcers	Yes	No	Diabetes	Yes	No
Cancer	Yes	No			

List any other history if not listed _____

Do you have any drug or food allergies? _____ List: _____

Comments: _____

Patient Signature: _____

Recording Started: _____ Ended: _____

Technologist(s): _____