Health Village Imaging

A Member of the Hackensack Meridian Health Network

PATIENT NAME: _____**DATE OF BIRTH**: _____

What part of the body will be imaged today? _____

Any prior tests that pertain to the reason you are having this test? _____

Why are you having this scan today? _____

How long have you had these symptoms? _____

Did you have an injury? **Yes** **No** If yes, when/where? _____

Please give date and type of surgery **related** to this body part:

_____

_____

List all personal cancer history: _____

Any possibility of pregnancy? **Yes** **No** **Don't know**

First date of last menstrual period? _____

Signing below indicates that you have read and understand this form and have completed it to the best of your ability.

Patient or Legal Representative Signature _____

Technologist Signature_____Date_____