



Bannockburn • Gurnee • Libertyville
(847) 599-1GRC

Date _____

PATIENT HISTORY

Area to be scanned _____

1. Please describe your symptoms.

2. Is this a recurring problem or a new problem? (Please explain)

3. Have you had any previous diagnostic testing for this condition?

Type of examination(s) _____

Date of examination(s) _____

Where was the examination(s) performed _____

Results (if known) _____

4. Is your pain related to trauma or injury? (Please explain)

Protocol:

Technologist _____ Radiologist _____