Radiology Imaging Center
www.agradiology.com

601 Park Grove
Katy, Texas 77450
Phone: (832) 321-3434
Fax: (832) 321-5031

Patient Name: _____ Today Date: _____

Referring Physician: _____ DOB: _____

Patient History:

Height: _____ Weight: _____

Reason your physician order this exam:

_____

_____

Next appointment with your referring physician: Date _____ Time _____

Are you experiencing pain or other symptoms at this time: Yes _____ No _____

If yes, please describe:

_____

_____

Have you had any other tests or procedures performed for the same symptom(s)? Yes ____ No _____

If yes, please list exam(s) and where it was done: _____

_____

Tech Notes:

_____

_____

_____

_____

TECH INITIALS: _____