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**AT NORTH ANDOVER**

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NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

CLINICAL HISTORY – please include signs and symptoms \_\_\_\_\_

REF PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

Wet Read? \_\_\_\_\_

Exam requested but not listed below: \_\_\_\_\_

Please Circle Exam Requested

These exams may be performed on a Walk-in Basis:					These exams need to be scheduled:						
X-Ray					Breast Imaging			Ultrasound			
Abdomen - KUB					Lower Leg	R	L	Bil	Mammogram - Screening		Abdominal
Abdomen - Flat & Uppt					Lumbar Spine				Mammogram - Diagnostic		Carotid
AC Joints					Mandible				Mammogram - Unilateral	R	L
Ankle	R	L	Bil		Nasal Bones				Ultrasound	R	L
Bone Age					Orbits				OB Ultrasound		
Cervical Spine					Pelvis				Less Than 14 Weeks		Pelvic
Chest					Ribs	R	L	Bil	Greater than 14 Weeks		Renal
Child - Upper Extr.	R	L	Bil		Sacrum & Coccyx				Biophysical Profile		Testicular
Child - Lower Extr.	R	L	Bil		Scapula	R	L	Bil	Bone Densitometry		Thyroid
Clavicle	R	L	Bil		Scoliosis Series				DEXA Scan:		Transvaginal
Elbow	R	L	Bil		Shoulder	R	L	Bil			Visceral
Facial Bones					SI Joints				Notes: _____ _____ _____ _____ _____ _____		
Femur	R	L	Bil		Sinuses						
Foot	R	L	Bil		Skull						
Forearm	R	L	Bil		Soft Tissue Lat Neck						
Hand	R	L	Bil		Sternum						
Heel	R	L	Bil		Thoracic Spine						
Hip	R	L	Bil		TMJs						
Humerus	R	L	Bil		Water's View						
Knee	R	L	Bil		Wrist	R	L	Bil			
Specific Views Requested: (e.g. AP & Lat only)											