

Patient History Questionnaire (CT)

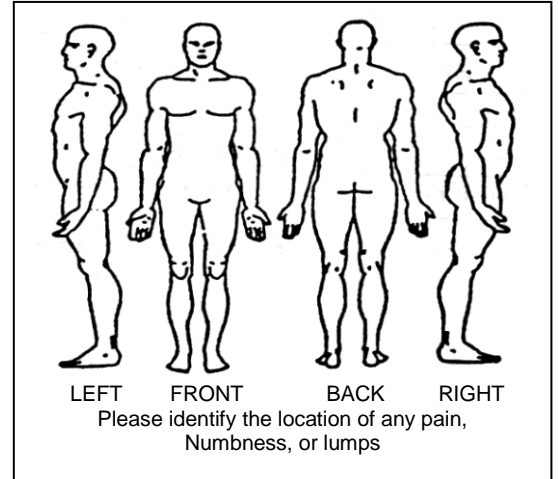
Patient Account Number: _____

Patient Name: _____ Date: _____

Date of Birth: _____ Weight: _____

Please describe your symptoms that necessitated a CT Scan:

How and when did these symptoms occur (e.g., injury, just started, etc.)?



Medical History:

1. Do you have or have you had any of the following:

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Kidney/renal disease | <input type="checkbox"/> Multiple myeloma | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Tumor, lump or mass | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Heart arrhythmia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Stroke | <input type="checkbox"/> History of smoking |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Asthma, bronchitis or emphysema | | |
| <input type="checkbox"/> Other illness or disease: _____ | | | | |

2. Have you had any tests (MRI, CT, X-Ray, etc.) performed for the symptoms you are currently experiencing? Yes No
 If yes, please list the date and type of test and where test was performed: _____

3. Have you had any surgeries? Yes No If yes, please identify the area of your body where the surgery was performed:

<input type="checkbox"/> Brain	<input type="checkbox"/> Heart	<input type="checkbox"/> Colon/Intestine	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Rectum	<input type="checkbox"/> Breast	<input type="checkbox"/> Liver	<input type="checkbox"/> Ovaries
<input type="checkbox"/> Spleen	<input type="checkbox"/> Appendix	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Prostate			
<input type="checkbox"/> Other: _____							

4. Do you have or have you had any food or drug allergies (e.g., Benadryl, prior X-Ray contrast agent reaction, etc.)? Yes No
 If yes, please list each food or drug allergy: _____

5. Are you currently taking any medications (e.g. Glucophage (METFORMIN), Glucovance (GYLBURIDE), etc.)? Yes No
 If yes, please list all medications you are currently taking: _____

Females Only:

6. Are you, or is it possible that you might be pregnant? Yes No Don't Know Are you breastfeeding? Yes No
 First day of last menstrual period ("LMP"): _____

I hereby certify that the above information is true and correct to the best of my knowledge.

 Patient or Legal Representative Signature

 Print Name and Authority (if legal representative)

 Date

Technologist Notes: _____