

DOB: Admit Date: ECD:

MRN:

COMPUTERIZED TOMOGRAPHY (CT) SCAN HISTORY

Side 1 of 2

SECTION I: TO BE	COMPLE	TED BY	PATIENT/REPRESEN	TATIVE		TO CT S	CAN		
):						
Other physician(s) r	reeding rep	ons.	\.						
Contact Information	(Address/F	none #): □ Ma	- Dr		Λ α α ι			
Height:	, V\	/eignt: _	Ma	ie 🗆 Fi	emale	Age.	to all a sais all	,	
Are you pregnant of	r possibly p	regnant	? □ No □ Yes □ No	t applical	bie L	ast mens	trual period:/	 /;	
			r your examination toda			fic medica	al problems, location a	and now I	ong
you've had the prob	olem):								
List other medical p	roblem(s):								
List previous surger							AND THE RESERVE OF TH		
,			an, when was it perform	ed and v	vhere?				
			Where	I I		hen	w	here	To a delicate the
WIICH			Milere			ПСП		nere	
			The state of the s	 		**************************************			
CONTRAST HISTO	RY					ente trancen			
Are you taking any	diabetic me	dication	? No Yes, what						
When did you last to	ake II!		ic reaction to X-ray co		\ 0 . [1.7		
have you ever nad	a previou	s allerg	ic reaction to X-ray co	ntrast (c	iye) r	INO	res, explain:		
			is examination: 🗌 No						
			ntly taking (include herba						
Medication		Reason			Dose	Taken How Often	Route		
	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·							
List any medicatio	n or food a	llergie	s and reactions:						
Have you aver had	radiation or	ah ama	thorony2 □ No. □ Voc				10/1		
		chemo	therapy? ☐ No ☐ Yes	s, what ty	/pe:		When:		
PERSONAL HISTO								—	
Asthma			Kidney Disease				ic Ovary Disease	□ No	☐ Yes
Bladder Disease			Liver Disease				Problems	□ No	☐ Yes
Cancer			Multiple Myeloma				ory Disease	□ No	Yes
Diabetes			Heart Disease			Stroke		□ No	Yes
Dizziness	□ No I		High Blood Pressure Implantable Device	□ No		Seizure Disorder Sickle Cell		□ No	Yes
Headaches	□ No I			□No	res	Sickle C	ell	☐ No	☐ Yes
If you answered "ye	s" to any of	the abo	ove items, please explain	n:					
			e best of my knowledge	and und	erstand	the infor	mation presented to n	ne. I hav	e also
informed the techno	logist that I	am not	pregnant at this time.						
							//_		
Signature of Patient or R	epresentative		Relationship to Pati	ent, if Rep	resentativ	ve	Date	Tim	ie
Reviewed by:									
							//		
Technologist/Radiation T	herapist's Sign	nature/Titl	e Print Name				Date	Tim	ie



X PATIENT NAME:
X DATE OF BIRTH:

COMPUTERIZED TOMOGRAPHY (CT) SCAN HISTORY

SECTION I: TO BE	E COMPLE	TED BY	PATIENT/REPRESEN	Side 1 of 2		CAN		
Referring/ordering	physician (N	lame):			No.			
Contact information	(Address/F	hone #):						
Other physician(s)	needing rep	orts:						
Contact information	(Address/F	Phone #)						
Height:	۱۸	deight:		ale	ale Age:			
Are you pregnant o	r possibly p	roanant?		ot applicable	Last mans	trual period:/	s 1	
						al problems, location a		
			your examination tous			ai problems, location a	and now long	
you ve had the prot	Jieiii)							
List other medical p	problem(s):							
List previous surger	ries:							
Medical test: If you	have had a	CT Sca	n, when was it perforr	med and when	re?			
When	mave nad e	Where		T Treatment	When	W	Where	
							A STATE OF THE STA	
				1				
CONTRAST HISTO	ORY	(124-144) (12-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-						
		dication?	□ No □ Ves wha	t is it:				
				t 15 it				
When did you last to	ake it?				10 CN - C	1 V		
have you ever had	a previou	s allergio	reaction to X-ray c	ontrast (dye))? [] NO [Yes, explain:		
			examination: 🗌 No		17510			
		u current	y taking (include herb					
Medic	cation		Reason		Dose	Taken How Often	Route	
List any medicatio	n or food a	allergies	and reactions:					
Have you ever had	radiation or	chemoth	nerapy? No Ye	es what type:		When:		
PERSONAL HISTO		- CHOINGE	.c.ap)	ro, what type:				
Asthma		□ Yes I	Kidney Disease	TONOLOS	Ves Polycyst	ic Ovary Disease	□No□Ye	
Bladder Disease	□ No	Yes	Liver Disease	No D	Yes Prostate	es Prostate Problems		
Cancer	□No		Multiple Myeloma		Yes Respiratory Disease		□ No □ Ye	
Diabetes	□No		Heart Disease		res Stroke □ No			
Dizziness	□No		High Blood Pressure				□ No □ Ye	
Headaches	□No		Implantable Device		Yes Sickle C		□ No □ Ye	
If you answered "ye	es" to any of	the abov	e items, please expla	ain:				
I have answered the	ese questio	ns to the	best of my knowledge	and underst	tand the infor	mation presented to n	ne. I have also	
informed the techno	ologist that I	am not p	regnant at this time.					
X			Χ			X / /	X	
Signature of Patient or F	Representative	9	Relationship to Pa	itient, if Represe	ntative	Date	Time	
Reviewed by:								
						1 1		
Technologist/Radiation T	Theraniet's Sign	nature/Title	Print Name			Date	Time	