CT & XR History Sheet

Patient Name: ________________________________ Date of Birth: __________ Age: ____
Weight: _____ Height:_______ Date of First Day of Your Last Menstrual Period: ___________

Please List All Surgeries**:** ____

____

Please List All Allergies: ____

Diabetic: ☐ No ☐ Yes: ☐ Type 1 ☐ Type 2: Insulin Dependent: ☐ No ☐ Yes

Smoker: Current/Former: How Long ______ & Cigarette Pack(s) per Day ______ Cigars per Day____

Do you have a Personal History of Cancer ☐ No ☐ Yes: Type/Location:________________________

If your symptoms are related to an injury what **DATE** and **LOCATION** did the injury occur? __/__/__

Please Circle Location: Home Work Motor Vehicle Accident Other:_______________

Circle All that Apply and Sign the form below:

Bone/Spine/Head

Trauma/Injury
Laceration/ Abrasion
Swelling
Arthritis: Osteo/Rheumatoid/Psoriatic
Neck/Upper-Mid/Low Back Pain
Pain in Right Arm/Leg
Pain in Left Arm/Leg
Weakness/ Numbness/ Tingling
Dizziness/Blurred Vision
Headaches
Sinus Congestion
Ankylosing Spondylitis

Abdomen/Pelvis

Pain
Diarrhea/ Constipation
Blood in Stool
Nausea/ Vomiting
Hernia
Ulcer
Gallbladder Stones
Kidney Stones: Previous/Current
Hematuria (Blood in Urine)
Incontinence/ Urinary Difficulty
Hypertension

Chest

Shortness of Breath/ Wheezing
Coughing
Fever
Chest Pain/ Difficulty Breathing
Heart Disease
Hypertension
Emphysema/ Asthma
Positive TB Skin Test
General Screening/ Pre-Op Testing

Patient Signature: Date:

For Use by Technologist Only: **Shielded:** □Yes

Tech Initials__________ Oral Contrast □ Yes □ No IV Contrast □ Yes □ No

Brand __________________ Lot ________________ Exp _____________CCs Injected _______

BUN ________ CREATININE ________ EGFR __________ Date Drawn___________

Exam:

History: