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: Years Smoking ______ Cigarette Pack(s) per Day ______ Cigars per Day____

Former: Years Quit______ Years Smoked________ Cigarette Pack(s) per Day ______

☐ Non- Smoker

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/Extremity
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
Ankylosing Spondylitis
Previous Spinal Fusion Surgery

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
Hypertension / Heart Disease
Emphysema / Asthma
Asbestos Exposure: Work / Home
Positive TB Skin Test
General Screening / Pre-Op Testing

Head/Neck
Trauma / Injury
Swelling / Mass / Lump
Dizziness / Light Headedness
Blurred Vison / Other Visual Disturbance
Headaches / Migraines
Sinus Congestion
Recurrent Sinus Infections
Difficulty Swallowing
Hoarseness / Other Voice Disturbance

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: