CT & XR History Sheet

Patient Name: _____ Sex: ____ DOB: _____ 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: