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 Check Location: ☐ Home ☐ Work ☐ Motor Vehicle Accident ☐ Other: _____

Check All that Apply and Sign the form below:

Bone/Spine/Limb

☐ Trauma / ☐ Injury
☐ Laceration / ☐ Abrasion
☐ Swelling
☐ Arthritis:
  ☐ Osteo / ☐ Rheumatoid / ☐ Psoriatic
☐ Pain In:
  ☐ Neck / ☐ Upper-Mid Back / ☐ Low Back
  ☐ Right Arm / ☐ Right Leg
  ☐ Left Arm / ☐ Left 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 / High Blood Pressure

Chest

☐ Shortness of Breath / ☐ Wheezing
☐ Coughing
☐ Fever
☐ Chest Pain / ☐ Difficulty Breathing
☐ Hypertension / High Blood Pressure
☐ Heart Disease
☐ Emphysema / ☐ Asthma
☐ Asbestos Exposure: ☐ Work / ☐ Home
☐ Positive TB Skin Test
☐ General Screening
☐ Pre-Op Testing
☐ Lung Nodule
☐ COVID 19: ☐ Personal History / ☐ Recent Exposure

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: _____