# CT/XR History Sheet

**(Please Write Neatly)**

Patient Name: _____ Sex: ____ DOB: _____ Age: ____

Weight: _____ Height: _____ Date of First Day of Your Last Menstrual Period: _____

Email (**Required** for digital images): _____

Please List All Surgeries**:** _____

_____

Please List All Allergies: _____

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

Smoker: ☐ Non-Smoker

Current: Years Smoking _____ Cigarette Pack(s) per Day _____ Cigars per Day_____

Former: Years Quit_____ Years Smoked_____ Cigarette Pack(s) 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?

____/____/_____ ☐ Home ☐ Work ☐ Motor Vehicle Accident ☐ Other: _____

**<u>Check</u> all that apply in the section related to your test and <u>Sign</u> the form below:**

## Bone/Spine/Arm/Leg

☐ 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
☐ Other _____

## 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
☐ Diverticulosis/Diverticulitis
☐ Other _____

## 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 / Blood Test
☐ General Screening
☐ Pre-Op Testing
☐ Lung Nodule
☐ Other _____

## Head/Neck

☐ Trauma / ☐ Injury
☐ Swelling / ☐ Mass /☐ Lump
☐ Dizziness / ☐ Light Headedness
☐ Blurred Vision / ☐ Other Visual Disturbance
☐ Headaches / ☐ Migraines
☐ Sinus Congestion
☐ Recurrent Sinus Infections
☐ Difficulty Swallowing
☐ Hoarseness / ☐ Other Voice Disturbance
☐ Other _____

Patient Signature: _____ Date: _____