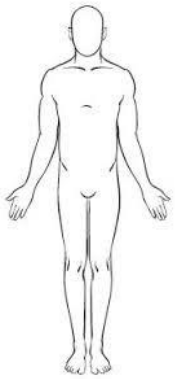
Patient Sticker

_____

Chesterfield Imaging
HCAVa
AN HCA AFFILIATE

CT PATIENT MEDICAL HISTORY

Please read carefully. Complete in its ENTIRETY



It is important for us to know your medical history to assist our radiologist as they review your study. If you have any questions please ask us to explain. Fill out the area that you are having problems with on the diagram to the right.

What type of problems are you having (why are you here)? _____

List Current Medications _____

Do you have symptoms or PERSONAL history of?

			YES	NO			YES	NO
Arm Pain	LT	RT				Dizziness		
Arm Weakness	LT	RT				Headaches		
Arm Numbness	LT	RT				Seizures		
Leg Pain	LT	RT				Stroke		
Leg Weakness	LT	RT				Heart Disease		
Leg Numbness	LT	RT				Kidney Disease		
Visual Problems	LT	RT				Diabetes		
Hearing Problems	LT	RT				High Blood Pressure		
Neck Mass	LT	RT				Liver Transplant		
Neck Pain	LT	RT				Cancer		
Speech Problems						Chemotherapy		
Balance Problems						Radiation Therapy		
Other:						Other:		

Please indicate any previous surgery:

Part	Date	Part	Date	Part	Date
Brain		Heart		Shoulder LT RT	
C. Spine		Gallbladder		Knee LT RT	
T. Spine		Intestines/Bowels		Hip LT RT	
L. Spine		Appendix		Foot/Ankle LT RT	
		Uterus/Ovaries		Other: _____	

Is there a possibility that you are pregnant? YES NO

Have you had a previous CT of this area? YES NO Where was the scan performed? _____

I have read and completed the above questions on the CT Patient Medical History Form. I have been provided the opportunity to ask any questions I may have. I verify this by signing below.

_____ _____

Patient or Authorized Representative Date

_____ _____

If not patient, relationship to patient Reviewed By (Technologist Signature)