

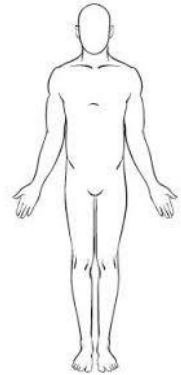
Patient Sticker



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)