


CT PATIENT MEDICAL HISTORY

Please read carefully. Complete ENTIRE form.

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

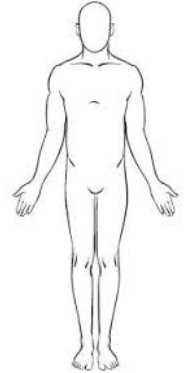
Indicate the area you are having problems with on diagram to right. 

List Current Medications _____

Have you taken any pre-medication? YES NO *If yes*, list: _____

Is there a possibility that you are pregnant? YES NO

Have you had a previous CT of this area? YES NO *If YES*, location: _____



Smoking History

Non Smoker Current Smoker Former Smoker: How many years ago did you quit for good? _____

How many packs per day you have smoked and for how many years. EX: This may vary for you, indicate each _____ packs/day for _____ years _____ packs/day for _____ years _____ packs/day for _____ years

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					
Removable glucose monitoring device						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: _____		

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)