CT HISTORY FORM

Patient Name: _____ MR#: _____ Date: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ ☐ Male ☐ Female

ALL FEMALES: Date of last menstrual period: _____ Are you or could you be pregnant? ☐ YES ☐ NO

Are you breast feeding? ☐ YES ☐ NO Are you postmenopausal? ☐ YES ☐ NO

►CHECK ALL SYMPTOMS RELATED TO THE TYPE OF CT SCAN YOU ARE HAVING

SHOULDER / ARM / ELBOW / HAND
HIP / LEG / ANKLE / FOOT

Body Part: _____

☐ Right ☐ Left

☐ Limited Range of Motion
☐ Weakness
☐ Popping
☐ Grinding
☐ Swelling
☐ Lump or Mass

Location of Pain:

☐ Front ☐ Back ☐ Inside ☐ Outside

Other: _____

BRAIN / IAC

☐ Headaches
☐ Seizures
☐ Weakness
☐ Trouble Walking
☐ Dizziness
☐ Speech Problems/Trouble Talking
☐ Hearing Problems ☐ Right ☐ Left
☐ Visual Problems ☐ Right ☐ Left
☐ Memory Loss

SPINE: Cervical / Thoracic / Lumbar

☐ Back Pain - Describe Below:
☐ Upper ☐ Middle ☐ Lower
☐ Neck Pain
☐ Weakness in:
☐ R Arm ☐ L Arm ☐ R Leg ☐ L Leg
☐ Pain in:
☐ R Arm ☐ L Arm ☐ R Leg ☐ L Leg
☐ Numbness in:
☐ R Arm ☐ L Arm ☐ R Leg ☐ L Leg

NECK (Soft Tissue)

☐ Lump or Mass
☐ Difficult Swallowing
☐ Difficulty Talking
☐ Pain
☐ Sore Throat

ABDOMEN

☐ Abdominal Pain - Describe Below:
☐ Sharp ☐ Dull ☐ Aching ☐ Burning
☐ Difficulty Swallowing
☐ Loss of Appetite
☐ Nausea / Vomiting
☐ Bowel or Bladder Changes
☐ Weight Loss or Gain

MALE PELVIS

☐ Pain
☐ Lump or Mass
☐ Trauma
☐ Pelvic Surgery
☐ Implant
☐ Hematuria
☐ Cancer
☐ Steroid or Radiation Therapy

FEMALE PELVIS

☐ Irregular Menstruation
☐ Painful Menstrual Cycles
☐ Painful Intercourse
☐ Hysterectomy
☐ Ovaries Removed

CHEST

☐ Difficulty Breathing
☐ Chest Tightness
☐ Chest Pain
☐ Moist Cough
☐ Dry Cough
☐ Heart Disease

INJURY / SURGICAL / RADIATION THERAPY

Did you injure the area of interest? ☐ YES ☐ NO If yes, describe: _____

Have you had past scans of the area we are scanning today? ☐ YES ☐ NO

If yes, approximately when was the scan done: _____ and at what facility: _____

Have you had previous surgery or radiation therapy on the area we are scanning today? ☐ YES ☐ NO

DO YOU HAVE		TECHNOLOGIST NOTES
Kidney disease or kidney injury?	☐ YES ☐ NO	_____
Kidney surgery, implant, single kidney?	☐ YES ☐ NO	_____
Are you on dialysis?	☐ YES ☐ NO	_____
Do you have diabetes?	☐ YES ☐ NO	_____
Do you have asthma?	☐ YES ☐ NO	_____

CT CONTRAST

Have you ever had an allergic reaction to CT Contrast? ☐ YES ☐ NO

I attest the above information is corect to the best of my knowledge. I have read and understand the content of this form. I have had the opportunity to ask questions regarding the CT procedure I am about to undergo.

Patient/Guardian Signature: _____ Today's Date: _____

3405 College Street, Beaumont, Texas 77701 Phone: (409)832-2211 Fax: (409) 434-4277