Center for Diagnostic Imaging
CT HISTORY FORM

Name _____ Date _____

Physician's Name _____

1. What was your chief complaint when you visited your doctor?
   _____

2. Did you ever have a CT scan before? Yes or No

   If yes, Where? _____ When? _____

3. Have you ever had IV Contrast for CT or IVP? Yes or No
   Did you have an allergic reaction? Please give details:_____

4. Do you have any FOOD OR DRUG or Asthma allergies? Yes or No

   If yes, to What: _____

5. What time did you last eat or drink anything?_____

| CHECK YES OR NO FOR THE FOLLOWING: | YES | NO |
|---|---|---|
| Multiple Myeloma | ___ | ___ |
| Renal Insufficiency | ___ | ___ |
| Have you experienced weight loss? | ___ | ___ |
| Blood in stool? | ___ | ___ |
| Do you have diabetes? | ___ | ___ |

If yes, list any medications taken to control diabetes: _____

Do you smoke or have a history of smoking? ____ ____
If yes: Packs per day_____ How long? _____

Have you ever been diagnosed with cancer? ___ ___

If yes, please give details: _____

Are you being treated for any other illness? ___ ___

If yes, please give details: _____

Have you ever had any surgery? ___ ___

If yes, what type and when? _____

*What influenced you to choose our facility for your Radiology needs?*

Doctor referral □ Advertising □ Friend or Family □ Other □ _____

Female patients only: When was your last menstrual period? _____

_____ _____
Patient Signature Date

Official Use: Lab Values: BUN: _____ Creatinine: _____