

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: _____		

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 LMP? _____

Patient Signature

Date

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