CT Information Sheet

Patient Name:	**Date of Birth:**	**Age:**

Next Appointment with Physician about these results:	**Height:**	**Weight:**

General Information		
What are your current symptoms?		
How long have you had this problem?		
Any previous imaging studies of body part being imaged?	❑ Yes ❑ No	If Yes, List type of study and date
Any new or past history of cancer?	❑ Yes ❑ No	If Yes, Explain
Any previous radiation treatment?	❑ Yes ❑ No	Last Treatment:
Any previous chemotherapy treatment?	❑ Yes ❑ No	Last Treatment:
Any injury related to the area being imaged? Date of Injury: ______________	❑ Yes ❑ No	If Yes, Explain injury:
Any mass in the area being imaged?	❑ Yes ❑ No	If Yes, Explain:
Any pain in body part being imaged?	❑ Yes ❑ No	If Yes, Explain:
Are you pregnant?	❑ Yes ❑ No	Last Menstrual Period:

Please check ALL symptoms that apply:						
❑ Fever	❑ Seizures	❑ Vomiting	❑ Hearing loss	❑ Limb pain	❑ TIA/CVA	❑ Trauma
❑ Nausea	❑ Cough	❑ Fainting	❑ Hematuria	❑ Diarrhea	❑ Headache	❑ Dizziness
❑ Visual problems		❑ Difficulty Swallowing		□ Shortness of breath	❑ Coughing Blood	
❑ Extremity Weakness		❑ Weight loss	❑ Constipation	❑ Slurred Speech	❑ None	
Smoking history: ❑ Never ❑ Current ❑ Past Year Quit________ ________Packs per day x ______years.						

Previous Surgeries:					
❑ None	❑ Hysterectomy	❑ Appendix	❑ Gallbladder	❑ Sinus	❑ Kidney
❑ Spleen	❑ Bowel	❑ Prostate	❑ Ovaries	Other:	

Other Medical Problen	❑ None	❑ Diabetes	❑ Asthma	❑ Emphysema	❑ Stroke	❑ Heart
❑ High blood pressure	❑ Multiple Myeloma	❑ Kidney disease	❑ Other:			

Allergies to Medications & Reactions:	❑ None	❑ Iodine	❑ Sulfa	❑ Penicillin	❑ Latex
❑ Others:					
Reactions:					
Have you ever been injected with contrast (x-ray dye) before?	❑ Yes	❑ No			
Did you experience:	❑ Shortness of breath	❑ Hives/Redness/Rash	❑ Swelling	❑ No Problems	

Current Medications: ____

CT Lung Screening Year: ______________________________

Patient Signature: _____________________________ Technologist Signature: _________________

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