SOUTH ATLANTA RADIOLOGY
CT PATIENT HISTORY SHEET

PATIENTS NAME: _____ **DATE**:_____

REASON FOR EXAM(Present Complaint requiring CT Scan)

_____

LIST ANY SURGERY:_____

_____

PAST OR PRESENT HISTORY OF CANCER: YES OR NO
If yes,what type? _____

PAST OR PRESENT HISTORY OF CHEMOTHERAPY? YES OR NO
If yes, date of last treatment: _____

PAST OR PRESENT HISTORY OF RADIATION THERAPY? YES OR NO
If yes, date of last treatment:_____

DO YOU HAVE /OR HAVE YOU EVER HAD A HISTORY OF:

High Blood Pressure? YES OR NO
Kidney Disease? YES OR NO
Asthma? YES OR NO
Sickle Cell Anemia? YES OR NO
Multiple Myeloma? YES OR NO
Scleroderma? YES OR NO
Diabetes? YES OR NO
If yes, what medication do you take ? _____
Medication Allergy? YES OR NO
If yes, please list:_____
Heart Disease? YES OR NO
If yes,please list:_____

ANY PREVIOUS CT STUDIES? YES OR NO
If yes, where and when?_____

PREVIOUS REACTION TO CONTRAST (X-RAY DYE, IODINE,IVP OR ANGIOGRAPHY)?
YES OR NO
If yes, describe reaction and treatment:_____