

01156101

CT PATIENT CLINICAL HISTORY FORM

NAME: _____ MRN: _____

DATE: _____ TIME: _____

Please answer the questions below to the best of your ability. These are meant to assist our radiologist as they interpret your exam.

AREA OF CONCERN

Please point to the area of your symptoms on the diagram. You may choose more than one. Also circle the body part involved in the box.

Right



Left

- Head
- Neck
- Chest
- Abdomen
- Pelvis
- Spine
- Arm
- Elbow
- Wrist/Hand
- Hip
- Leg
- Knee
- Foot/Ankle

Please explain your symptoms: _____

When did your problem develop? _____ How did your problem develop? _____

Did you ever have any type of surgery on the area being scanned today? () Yes () No If "yes",

What type surgery? _____

When was the surgery? _____

Any history of cancer? () Yes () No If yes, what type and what therapy have you had: _____

When? _____

Have you ever had a CT scan of this area before? () Yes () No If Yes, When _____

Where was the scan performed? _____

Completed by: _____ Date: _____ Time: _____