MEDARVA
IMAGING

CT Patient History

Patient Name: ______________________
Date of Birth: ______________ Age: ________
Referring Physician: ______________________
Any chance you are pregnant? ☐ Yes ☐ No

Date of Exam: ______________________
Height: ____________ Weight: ________
Male ☐ Female ☐
Date of Last Menstrual Cycle: ______________

Medical History

List symptoms you have that are related to your problem:
Ex: pain, nausea, weight loss, etc.
____
____
____

List other tests you have had related to this problem:
Ex: Lab, X-ray, Ultrasound, MRI, CT
Include dates and locations.
____
____
____

Do you now or did you ever smoke? ☐ Yes ☐ No
If yes, for how many years? ____________
How many cigarettes per day? ____________

List any surgeries you have had and what they were for:
Include date and type of surgery.
____
____
____

Do you have or have you ever had cancer? ☐ Yes ☐ No
If yes, what type and body part?
____
____

What type of treatment did you receive?
____

Are you finished with treatment? ☐ Yes ☐ No

Did you injure the area of interest? ☐ Yes ☐ No
If yes, describe below:
____

Screening Questions

List all medications you are taking and what they are for:
____
____
____
____
____
____

Do you have any electronic medical devices? ☐ Yes ☐ No
Ex: Pacemaker, Defibrillator, Neuro-stimulator, Retinal implant, Insulin pump, Cochlear implant, etc.
If yes, list type of device below:
____
____
____

Patient/Guardian Signature: ______________________ Date: __________
Technologist Signature: ______________________ Date: __________

For Staff Use Only

Contrast: ______________ Amount: ________cc
Injection Site: ______________________
Injected By: ______________ Patient Response: ______________________
Additional Notes: ______________________
____