SJRA

SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

PATIENT MUST COMPLETE

CT History Form

DATE: _____

PATIENT NAME: _____

DOB: _____ Weight _____

Exam requested _____ Exam date _____

1. Why are you having this examination (medical problem) including symptoms _____

   _____

   _____

2. How long have you had these symptoms? _____
3. Circle the level of pain you experience: 0 1 2 3 4 5 6 7 8 9 10 (most severe)
4. Have you ever had a CT Scan before? ○ **Y** ○ **N** If yes, where: _____
5. Have you had a radiologic study / x-ray relating to this study? ○ **Y** ○ **N** If yes, when / where:

   _____

6. Have you ever been treated or diagnosed with cancer? ○ **Y** ○ **N** If yes, what type / when:

   _____

7. Have you ever had any major surgery? ○ **Y** ○ **N** If yes, what / when:

   _____

8. Are you or have you ever been a smoker? ○ **Y** ○ **N** If yes and you have quit, when? _____
9. Do you have a cardiac pacemaker or defibrillator? ○ **Y** ○ **N**

Technologist use only:

DX codes _____

Prior relevant studies: _____

Additional notes: _____

_____

_____Tech initials: _____