CT ORTHO HISTORY FORM

Patient MUST Complete
DOS: ______________

PATIENT #: ________________________
PATIENT NAME: ______________________________
DOB: ____________ / AGE: _______ / SEX: ______

*** **Please answer the following questions about your medical history to the best of your ability. Our Radiologists and staff will use the information you provide to select the most appropriate imaging techniques and to interpret the examination in order to best serve you! If you have any questions, please do not hesitate to ask.** ***

Please describe the symptoms you are having that led to this test.
If you are in **PAIN**, please tell us where and which side (RIGHT/LEFT).

WEIGHT:

____

____

How long have you had these symptoms/problems (days/weeks/months/years)? ______________________

□ Yes □ No - Was this a result of trauma/injury? If yes, please describe what happened: ______________________

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□ Yes □ No - Do you have a history of degenerative (osteoarthritis) or inflammatory arthritis (e.g. rheumatoid or gout)? (Circle)

□ Yes □ No - Have you ever had surgery on the part of your body being imaged? If yes, please describe the surgery:

____

□ Yes □ No - Do you have a history of cancer? If yes, what type and when was it diagnosed (month/year)? ______________

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If yes, describe how your cancer was treated (radiation/gamma knife/proton/chemo/surgery)? Please list approx. dates of treatment/procedures ______________________________

Please list what/when/where you've had prior studies of this body part (MRI/CT/X-Rays/US/Angio/Nuclear Med)

FOR WOMEN: Date of last menstrual period: ______________
Are you pregnant or think you could be? □ Yes □ No   Have you had a hysterectomy? □ Yes □ No
Are you using any form of birth control? □ Yes □ No ------------ If yes, list: ______________________

TECHNOLOGIST USE ONLY

Comments: ____

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____

______________________________ CT Technologist: ______________ Ext: ________

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I attest that the above information, including technologist's comments above, is correct to the best of my knowledge. I have read and understand the contents of this form. I have had the opportunity to ask questions regarding the information on this form and regarding the CT procedure that I am about to undergo.

Signature of Person Completing Form: ______________________________ **Date:** ____________

If Form Completed By Someone Other than the Patient (Print name): ______________________

Relationship: ______________________