CT BODY HISTORY

SJRA
SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

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 (days/weeks/months/years)?_____

Circle the level of pain you experience – 0 1 2 3 4 5 6 7 8 9 10 (most severe)

□ Yes □ No - Are you a current smoker?

□ Yes □ No - Did you smoke in the past? If you quit, how long ago? _____

□ Yes □ No - Have you ever had the following (please circle): COPD, emphysema, asthma, heart disease, aneurysm of the aorta, reflux or GERD (gastroesophageal reflux disease), hepatitis or liver disease, gallbladder disease or gallstones, pancreatitis, kidney stones, bowel obstruction, Crohn's disease, diverticulitis, colitis, endometriosis, fibroids, hernia.

□ Yes □ No - Have you had surgery of the heart, lungs, liver, gallbladder, pancreas, kidney, bladder, uterus, ovary, other (circle)?

If yes, please describe the surgery: _____

□ Yes □ No - Do you have a history of cancer of the lung, breast, colon, kidney, ovary, uterus, prostate, lymphoma (circle)?

If yes, when was it diagnosed (month/year)? _____

If yes, describe how your cancer was treated (radiation/gamma knife/proton/chemo/surgery) (circle)?

Please list approx. dates of treatment/procedures:

_____

Please list what/when/where you've had prior studies of this body part (MRI/CT/XRays/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: _____

_____

_____ CT Technologist:_____Ext:_____

I attest that the above information, including technologist's comments, is correct to the best of my knowledge. I read and understand the contents of this form and 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: _____