CT CHEST 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 reason or symptoms you are having that led to this test.
If applicable, please describe where and what side (RIGHT/LEFT).

WEIGHT:

_____

_____

How long have you had these symptoms (problems)? _____

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)

□ Yes □ No - Have you had surgery of the lungs, heart, other?
If yes, please describe the surgery: _____

□ Yes □ No - Do you have a personal history of lung cancer? If yes, right lung or left lung? (Please circle)

□ Yes □ No - Do you have a personal history of other cancer? If yes, what type and when was it diagnosed?

_____

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/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 information on the form above, including technologist comments above, is correct to the best of my knowledge. I have 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: _____