# 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:

_____

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

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: _____

_____

□ 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)? _____

_____

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 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:** _____