Inland Empire Imaging Center

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PATIENT MEDICAL HISTORY
CT

Date: ____/____/____ Referring Physician: _____ ID #_____

Last name: _____ First name: _____ ☐Male ☐Female

Date of birth: ____/____/____ Age: _____ Height: _____ Weight: _____

Do you currently have:	YES	NO
Allergies?	( )	( )
Asthma?	( )	( )
Do you have a history of:		
Kidney failure?	( )	( )
Heart disease?	( )	( )
Reaction/Allergy to X-Ray contrast?	( )	( )
Are you diabetic?	( )	( )
Are you insulin dependent?	( )	( )
Do you take Metformin?	( )	( )
Are you or is there a possibility you could be pregnant?	( )	( )
Do you currently have or have you had cancer?	( )	( )

If yes, what part of your body was affected? _____

Have you had any recent surgeries? ☐Yes ☐No

If yes, when? _____ For what? _____

Have you had any precious CT scans done before? ☐Yes ☐No

If yes, when? _____ Where? _____

_____ _____

PATIENT SIGNATURE DATE

---TO BE FILLED OUT BY RADIOLOGY---

Previous study: _____

Facility name: _____

Date of service: _____

Today's study: _____

☐With_____ Contrast

☐ Without Contrast

ACQUISITION TYPR: 2D TECHNOLOGIST:_____ DLP _____ mGy

IV: _____ PO: _____