



**CT Scan Patient History And Information**

Date of Exam: \_\_\_\_\_ Arrival Time: \_\_\_\_\_ SSN: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
(Last) (First) (Middle)

Height \_\_\_\_\_ \*Weight \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

Previous x-rays, MRI's, or CT's pertinent to this exam?  Yes  No  
When? \_\_\_\_\_ Where? \_\_\_\_\_

Has the patient ever been given Iodine X-ray contrast?  Yes  No

If yes, were there any allergic reactions?  Yes  No

Please explain reaction: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Is Patient Pregnant?  Yes  No Date of LMP: \_\_\_\_\_

Is Patient Diabetic?  Yes  No Medications: \_\_\_\_\_

If yes, do you take Glucophage or Glucovance?  Yes  No

Date Last Taken? \_\_\_\_\_

**Additional Comments: (Reason for Exam)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Patient Signature**