Radiology Imaging Center

# CT without Contrast History and Screening Form

Patient Name _____ Date _____

Date of Birth _____ Age _____ Weight _____ Sex ☐Male ☐Female

What is the reason for the CT today _____

_____

Have you had any previous X-Rays, MRIs, CTs, or Ultrasounds? ☐Yes ☐No

**If yes** : What _____ When_____ Where_____

Please answer the following:

☐Yes ☐No Do you have history of Cancer?

If yes, what type? _____

☐Yes ☐No Radiation therapy? Chemotherapy?: ☐Yes ☐No

**For Female patients:**

☐Yes ☐No Are you pregnant? Date of last menstrual period: _____

☐Yes ☐No Are you currently breast feeding?

List all previous surgeries: _____

_____

List all medications you take regularly: _____

_____

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I HAVE READ AND UNDERSTAND THE ENTIRE CONTENT OF THIS FORM AND I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS REGARDING THE INFORMATION ON THIS FORM.

Signature: _____ Date: _____

**Stop Here- To be completed by the technologist**

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Technologist_____

Reason for exam

_____

Pertinent history

_____

_____