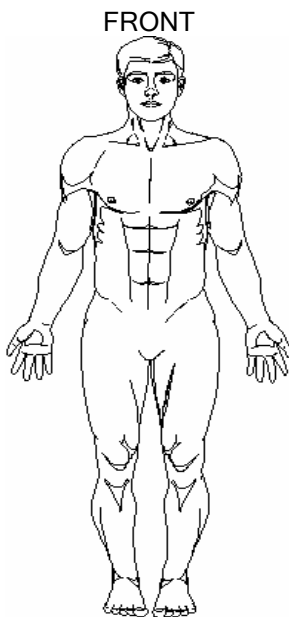


**CT SCAN PATIENT CLINICAL HISTORY SHEET**

Name \_\_\_\_\_ Date \_\_\_\_\_

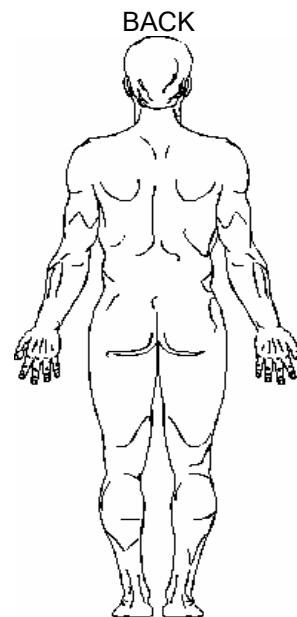
Please answer the questions below to the best of your ability. These are meant to assist our Radiologists as they interpret your exam.

Please shade the area of your symptoms and area(s) of concern on this diagram. You may choose more than one.



Area (s) of concern

- Head
- Neck
- Chest
- Abdomen
- Pelvis
- Spine
- Arm
- Elbow
- Wrist/Hand
- Hip/Leg/Knee
- Foot/Ankle



Please describe your symptoms: \_\_\_\_\_

When did your problem develop? \_\_\_\_\_ How did your problem develop? \_\_\_\_\_

What do you think your diagnosis is? \_\_\_\_\_ Do you have a history of cancer? \_\_\_\_\_

If yes, what type and what therapy? \_\_\_\_\_ Do you smoke? \_\_\_\_\_

Did you ever have any type of surgery on the area being scanned today? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, what type of surgery \_\_\_\_\_

When was the surgery? \_\_\_\_\_

Have you ever had a CT scan of this area before \_\_\_ Yes \_\_\_ No If yes, when? \_\_\_\_\_

Where was the scan performed? \_\_\_\_\_

Signature (Sign Here) \_\_\_\_\_