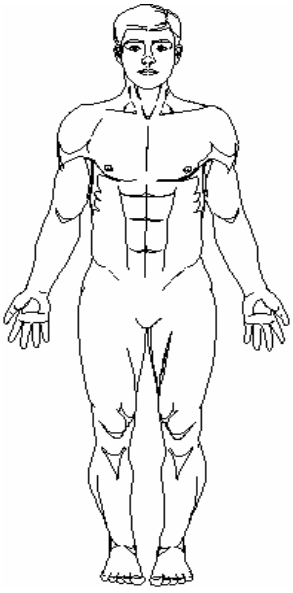
CT SCAN PATIENT CLINICAL HISTORY SHEET

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.

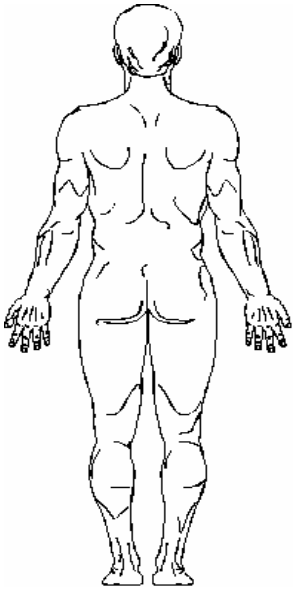
FRONT



Area (s) of concern

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

BACK



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) _____