CT NEURO HISTORY

SJRA
SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete
DOS: ____ / ____ / ____

PATIENT #: _____
PATIENT NAME: _____ _
DOB: _____ / _____ / _____ / AGE: _____ / SEX: _____

***** Please answer the following questions about your medical history to the best of your ability. Our Radiologists and staff will use the information you provide to select the most appropriate imaging techniques and to interpret the examination in order to best serve you! If you have any questions, please do not hesitate to ask. *****

Please describe the symptoms you are having that led to this test.

WEIGHT:

_____

_____

How long have you been having symptoms (days/weeks/months/years)? _____

□ Yes □ No - Was this related to injury/trauma? If yes, what happened? _____

_____

□ Yes □ No - Are you in pain? If yes, please describe which side and where. Circle (RIGHT/LEFT)_____

_____

□ Yes □ No - Do you have a personal history of cancer? If yes, what type and when was it diagnosed? _____

_____

If yes, describe how your cancer was treated (radiation/chemo/surgery)? Please list approx dates of treatment/procedures

_____

Please list any other medical problems you have: _____

_____

Please list all surgeries you have had, along with approximate dates: _____

_____

Please list what/when/where you've had prior studies of the same body part (MRI/CT/XRays/US/Angio/Nuclear Med)?

_____

FOR WOMEN: Date of last menstrual period: _____
Are you pregnant or think you could be? □ Yes □ No Have you had a hysterectomy? □ Yes □ No
Are you using any form of birth control? □ Yes □ No ---------- If yes, list: _____

TECHNOLOGIST USE ONLY

Comments: _____

_____

_____CT Technologist: _____Ext: _____

I attest that the information on the form above, including technologist comments above is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the CT procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date: _____

If Form Completed by Someone Other than the Patient (Print name):_____

Relationship: _____