EAGLES LANDING HEALTH
Providing care at your convenience.

CT Patient History Sheet

Date: _____

Patient Name: _____ D.O.B. _____/_____/_____

Patient Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Reason for Exam (present complaint requiring CT Scan): _____

_____

Are you pregnant? □ Yes □ No

Do you have any reason to believe you might be pregnant? □ Yes □ No

Are you nursing an infant? □ Yes □ No
If yes, stop nursing for 48 hours after contrast injection.

Date of your last menstrual period: _____

List any surgeries:

_____

_____

Past or Present history of Cancer? □ Yes □ No
If yes, what type? _____

Past or Present history of Chemotherapy? □ Yes □ No
If yes, date of last treatment: _____

Past or Present history of Radiation Therapy? □ Yes □ No

Do you take Metformin containing drugs (these are medications for diabetes or PCOS, e.g., Glucophage or Glucovance)? If you are unsure, speak with the technologist. □ Yes □ No

Do you have or have you ever had a history of:

High Blood Pressure	□ Yes	□ No
Kidney Disease	□ Yes	□ No
Asthma	□ Yes	□ No
Sickle Cell Anemia	□ Yes	□ No
Multiple Myeloma	□ Yes	□ No
Scleroderma/Lupus	□ Yes	□ No
Diabetes	□ Yes	□ No

If yes, what medication do you take? _____

Medication Allergy □ Yes □ No
If yes, please list: _____

Heart Disease □ Yes □ No
If yes, please list: _____

Any previous CT studies? □ Yes □ No
If yes, where and when? _____

Previous reaction to contrast (X-ray Dye, Iodine, IVP or Angiography)? □ Yes □ No
If yes, describe reaction and treatment: _____

_____

Patient Signature: _____ Date: _____

***By signing this form, I hereby attest that all information on this form is true and correct.**