



CT Patient History Sheet

Date: _____

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

Best Contact Number: ____-____-____ Height _____ Weight _____

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

Date of your last menstrual period: _____

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

List any past surgeries done in the area being scanned today (i.e. Appendectomy/hysterectomy):

Are you currently experiencing Pain? Yes No If yes, list location of pain: _____

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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sickle Cell Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Multiple Myeloma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scleroderma/Lupus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Diabetes Yes No If Yes, what Medication do you take: _____

Medication Allergy Yes No If Yes, please list: _____

Heart/Vascular Disease Yes No If Yes, please list: _____

Chemotherapy Yes No If yes, date of last treatment: _____

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.**

Office Use only:

Additional Information for Radiologist: _____

Type of CT Scan: _____ Dose: CTDI: _____ DLP: _____

Contrast: _____ Volume: _____ MLPS: _____ Lot #: _____ Expiration: _____

Patient Account Number: _____ Name of Ordering Provider: _____

CT Technologist Signature: _____



Insurance Waiver

Date of service: _____

Patient Name: _____

Account #: _____

Provider Name: _____

Exam/Procedure/Service: _____

I elect to receive services today for the services listed above and agree to pay any and all of the balance due related to this procedure if not covered by insurance. Possible denial reasons are listed below:

- These services may be non-covered by my insurance for any reason
- These services may not be eligible for payment under my specific benefits and plan
- This provider may not be recognized under my insurance plan for payment

I have read and understand that by signing this waiver, I am consenting to receive the above mentioned services and understand that I *may* incur a balance due to these services not being covered by my insurance policy. I elect to receive the services anyway and agree to pay any balance due.

Signature of Patient or Guardian

Date: _____

If we cannot verify your insurance, you will be considered Self Pay