IMAGING CENTER at CYPRESS
CT PATIENT HISTORY

Name:_____ **Date of Birth**:_____
(print)

Current Weight _____ lbs **Height** _____feet _____inches

Date symptoms began: _____ **Describe your symptoms below**:

_____

_____

_____

Have you ever been diagnosed with cancer Yes No
If yes, what type and year diagnosed _____
Treatment: Chemotherapy Yes No
Radiation Yes No

Have you ever been diagnosed with COVID Yes No If yes, when _____

Is this exam due to an injury Yes No If yes, when _____

Do you smoke Yes No If you quit, what year _____

Have you had a previous study in the area of the body being scanned today?

CT:	Yes	No	If yes, when and where _____
MRI:	Yes	No	If yes, when and where _____
Nuc Med:	Yes	No	If yes, when and where _____
Ultrasound:	Yes	No	If yes, when and where _____
X-Ray:	Yes	No	If yes, when and where _____

List all surgeries in the area of the body being scanned today and year performed if known:

_____

_____

Are you diabetic	Yes	No
High blood pressure	Yes	No
Kidney disease	Yes	No
Have only one kidney	Yes	No
Any kidney surgery	Yes	No
History of multiple myeloma	Yes	No
History of renal tubular acidosis	Yes	No
Current pyelonephritis	Yes	No
Do you have Lupus	Yes	No
Chemo in the last 3 mo	Yes	No
Allergy to Benadryl or steroids	Yes	No
Iodine Allergy or previous reaction to CT contrast	Yes	No

Describe CT contrast Reaction:_____

FEMALES ONLY: **Any chance you are pregnant** Yes No
IF NO, *WHY* _____

Patient Signature: _____ **Date**: _____