PROHEALTH Advanced Imaging UIC

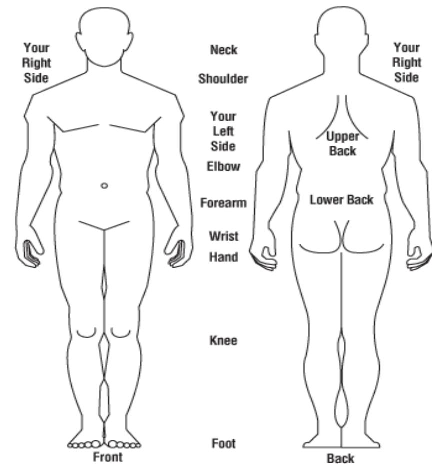
CT SCAN PATIENT CLINICAL HISTORY SHEET

Name: ____ DOB: ___/____/_____

Sex: __________ Age: ______ Approx. Weight: _______lbs. Height: _________

1) Is there any chance of pregnancy? ____Yes ____No If Yes, are you breast Feeding? ____Yes ____No
2) Have you had any previous contrast studies within the past couple of days? ____Yes ____No
   If yes, Where and When? ____
3) Have you had any reactions to a contrast dye? ____Yes ____No If yes, what reaction occurred:
   ____
4) Please list allergies:
   ____
5) Please list previous Surgeries:
   ____
6) Do you have any of the following medical conditions?
   Asthma? ____Yes ____No Lung Disease? ____Yes ____No
   Shortness of Breath? ____Yes ____No High Blood Pressure? ____Yes ____No
   Multiple myeloma? ____Yes ____No Heart Disease? ____Yes ____No
7) Are you diabetic? ____Yes ____No
   If yes, are you taking? Glucophage____ Metformin____ Glucovance____
8) Have you ever been diagnosed with cancer/serious illness? ____Yes ____No if yes, please explain
   ____

<u>REASON FOR PROCEDURE:</u> Please check any of the following symptoms that you are experiencing related to today's exam:



Chest Pain _____ Seizures _____

Headaches _____ Unexpected weight loss _____

Nausea _____ Hearing Loss _____

Abdominal Pain _____ Blackouts _____

Blurred Vision _____ Ringing in Ears _____

Pelvic Pain _____ Dizziness _____

Memory Loss ____ Back Pain _____ Neck Pain _____

Shoulder pain_____ Right Left Numbness _____ Right Left

Leg Pain _____ Right Left Weakness _____ Right Left

Arm Pain _____ Right Left Other: ______________________________

Signature: ______________________________________ Date: ______________________