



MUSCULOSKELETAL CT HISTORY FORM

Referring Physician _____ Accession # _____

Patient Name: _____
(Last) (First) (Middle)

Birthdate: _____ Age: _____ Today's Date: _____

Is there any possibility you may be pregnant? _____ Weight: _____ lbs. Height: _____

In one sentence, describe what made you go see your doctor: (i.e. lump, pain swelling, numbness etc.)

Describe your symptoms: _____

Did your difficulty happen over years? _____ Months? _____ Weeks? _____ Days? _____
Suddenly? _____

Was this related to a car accident or work related injury? _____

Is this related to a fall or sports injury? _____

Please explain the problem below _____

Describe your general health: _____

Do you have any medical conditions that we should know about? Please list _____

Do you have cancer or a history of cancer? _____

Do you have any allergies or asthma? _____

Do you have any allergies to x-ray dye? _____ if so, explain reaction: _____

Please list the medications that you are currently taking: _____

Have you had a previous CT or MRI of this region before? _____ What type? _____

Location and date of procedure: _____ What were the findings? _____

Signature: _____