



ABDOMEN AND / OR PELVIS 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: _____
Have you had any nausea or vomiting? _____ Comments? _____

Have you had a change in your bowel habits? _____ Describe: _____

Have you gained or lost weight? _____ How much? _____

Have you had any surgery? _____ When and what for? _____

Have you had abnormal lab or x-ray tests? _____ What were they? _____

Please list any medications that you are taking currently: _____

Do you have any allergies or asthma? _____ Have you ever had x-ray dye? _____

Have you ever had a reaction to any x-ray dye? _____ If yes, please specify: _____

Do you have any medical conditions that we should know about? _____ Describe: _____

Have you had a previous CT or MRI of this region before? _____ What type? _____
Date: _____ Location of procedure _____ What were the findings? _____
Signature _____