



CHEST / HEART 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:

Describe your symptoms: _____

What do you think caused the problem? _____
Describe your general health: _____

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

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 chest x-rays, cardiac catheterizations, CT's or MRI's of this region before? _____ What type? _____ Date: _____

Location of procedure: _____ What were the findings? _____

Signature: _____