

Name: _____ D.O.B. ____/____/____ Age: _____ Sex: M/F
(Last) (First)

WT: _____ HT: ____ft. ____in. Referring Physician: _____

- Please provide a summary of your symptoms specific to your exam today: _____

- What is/was the cause of the problem? Accident / Motor Vehicle / Fall / Work-Related Injury (Complete Injury Form)
- Are you having pain? Yes____ No____ If Yes circle if pain is severe / moderate / mild
- Do you have a history of being diagnosed with cancer? Yes ____ No____ When? _____ Type? _____
- Have you been treated with either: Radiation or Chemotherapy? Date started _____ Completed _____
- Have you taken a drug call AVASTIN? YES NO If Yes, when was the last time your received the drug AVASTIN? _____
- Do you wear a Dexcom glucose monitor? Yes ____ No ____ *If Yes, please inform your technologist before exam*
- Any surgery on area being imaged? Yes____ No____ If yes, when and what type? _____
- Prior Diagnostic Imaging of the area being scanned today? Yes____ No____
If yes, Date/Study/Facility _____
- Have you had a biopsy on this area? Yes ____ No ____ if so, what were the results? _____

Female patients:

- Are you pregnant or possibly pregnant? Yes____ No____ Date of last menstrual period _____

I acknowledge that all the information given is accurate and thereby consent to have CT with or without an injection of contrast performed on me.

Patient's signature: _____ **Date:** ____/____/____ **Technologist Initials:** _____

TECHNOLOGIST NOTES: _____
