

RAI PATIENT HISTORY CT CHEST/ABDOMEN/PELVIS:

Today's Date: _____

Name: _____ Age: _____ Weight: _____ Height: _____ Referring Physician: _____

1. What part of the body will be scanned today: _____

2. Describe your current problems/symptoms: _____

_____ Length of symptoms: _____

3. Any surgery in the AREA being scanned: Circle- Y - N When? _____ What was done? _____

4. Have you been diagnosed with cancer? Circle: Y - N Please provide type and location (ex. melanoma on left shin; breast cancer, right upper inner quadrant) _____

5. Prior surgery/biopsy related to cancer: Site _____ Facility _____
Date _____

6. Treatments related to cancer:
Chemo - if yes, date of last treatment _____ provide date of any future treatments planned _____

Radiation - if yes, date of last treatment _____ provide date of any future treatments planned _____

Other treatment - please describe and provide dates: _____

6. Describe any existing medical conditions (high blood pressure, diabetes): _____

7. Do you have a history of smoking? Circle: Y - N Former: _____ Current: _____ Number of years smoking: _____

8. List ALL current medications: _____

9. Do you have any known allergies: _____

10. If Injury/Accident/MVA -

a. **Exact Location** (ex. Anterior chest wall, muscle, abdomen): _____

b. **Type of Injury/Symptoms** (Circle One): 1. Sprain 2. Strain 3. Abrasion 4. Contusion 5. Crush Injury 6. Laceration
6. Penetrating 7. Other _____

c. **Which side of your body?** (Circle One): Right Left Bilateral (Right and Left)

11. Prior Diagnostic Imaging: Chest/Abdomen/Pelvis Studies (XRAY/US/CT/MRI)

Study/Date/Facility: _____

13. Has your physician prescribed any sedation or medication specifically for this examination? Yes - No
If yes, please indicate drug type and amount _____

14. FOR FEMALE PATIENTS:

- 1. Date of last menstrual period: _____ Post-menopausal? Yes - No (Circle which apply)
- 2. Are you pregnant or experiencing a late menstrual period? _____ Yes - No

I recognize that if I am pregnant and have radiation to the abdomen/pelvis there is a possibility of injury to the fetus. However, I understand that the likelihood of such injury is slight and that my physician feels that the information to be gained from this exam is important to my health. I, therefore, wish to have this exam performed now.

Signature _____ Date: _____

I attest that the answers I have provided to the questions on his form are correct to the best of my knowledge.

Patient signature: _____ Date: _____

Parent or Guardian signature: _____ Relationship: _____ Date: _____

Technologist signature: _____ Date: _____

Comments: _____

_____ Tech/TechAide initials _____