RAI PATIENT HISTORY CT SOFT TISSUE NECK: **Today's Date:**_____

Name: _____Age: _____ Weight: _____ Height:_____ Referring Physician:_____

1. Describe your current problems/symptoms:_____

_____Length of Symptoms:_____

2. Is there a lump in your neck? Circle: Yes - No Which side: RIGHT - LEFT

3. Have you had a biopsy on this area? Circle: Yes - No What were the results?_____

4. Any surgery on Neck: Circle: Y - N When? _____What was done?_____

5. Do you have a history of head/neck cancer? Circle: Y - N Type? _____

6. Treatments related to head/neck 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: _____

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

_____

8. List ALL current medications: _____

9. Do you have any known allergies:_____

10. If Injury/Accident/MVA –

a. Exact Location (ex. Muscle, blood vessel): _____

b. Type of Injury/Symptoms (Circle One): 1. Abrasion 2. Contusion 3. Laceration/Open Wound 4. Penetrating 5. Sprain
6. Foreign Body 7. Swelling 8. Other_____

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

11. <u>Prior Diagnostic Imaging: Soft Tissue Neck Studies (US/MR/CT):</u>

Study/Date/Facility:_____

_____

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

13. 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_____