ABERCROMBIE RADIOLOGICAL CONSULTANTS, INC.
MEDICAL HISTORY
Please Print

Date _____

Name _____ D.O.B _____ Weight _____lbs

What problems are you having that this test is to help answer? _____

_____

_____

Any previous CT scan, Ultrasound, Chest, Spine or Barium x-rays? If yes, where? _____

Do you smoke? YES NO

Former smoker: When did you quit? _____

Do you have asthma, allergies or hay fever? YES NO

If yes, please list _____

Have you ever had x-ray contrast dye? (Kidney dye or CT dye) YES NO

If yes, did you have a reaction? YES NO

What kind of reaction? _____

Have you ever had MRI contrast dye? YES NO

If yes, did you have a reaction? YES NO

What kind of reaction? _____

MEDICAL HISTORY

Check if you have any of the following:

❑ Lung Problems ❑ Liver Disease/Cirrhosis ❑ Aneurysm Clips ❑ Previous Head Injury

❑ Multiple Myeloma ❑ Fatigue/Weakness ❑ Metal Sliver in Eye ❑ General Severe Debilitation

❑ Renal Disease ❑ High Blood Pressure ❑ Pacemakers/Electronic Implants

❑ Heart Problems ❑ Anemia ❑ Seizures

❑ Explain Heart Problems: _____

❑ Diabetes – If yes, are you taking Glucophage or Metformin? YES NO DO NOT KNOW

If yes, has your doctor asked you to stop taking it for this test? YES NO

❑ Cancer? (List types) _____

Surgery for cancer YES NO Dates _____

Chemotherapy YES NO Date of last chemo _____

Radiation Therapy YES NO Date of last radiation _____

Previous CT or MRIs YES NO Where _____

PREVIOUS SURGERY

Type: Date:

_____ _____

_____ _____

_____ _____

Are you taking any medications? YES NO

If yes, please list _____

FOR FEMALE PATIENTS:

What is the approximate date of your last menstrual period? _____/_____/_____

Is there a possibility you could be pregnant? YES NO

Are you currently breastfeeding? YES NO

OFFICE USE ONLY:

Contrast and Amount _____ Time of inject_____

Technologist Signature _____