# 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, MRI, Nuclear Medicine exams, X-ray's or Barium studies? (Circle)

If yes, where? when?___________________________________________________________________________

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? _________________________________________________________________________

Do you smoke? YES NO

Former smoker: When did you quit? _________________ How many years did you smoke? ________

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

If yes, please list _____________________________________________________________________________

**MEDICAL HISTORY**

**Check if you have any of the following:**

❑ Lung Problems ❑ Liver Disease/Cirrhosis ❑ Anemia ❑ Previous Head Injury

❑ Multiple Myeloma ❑ Fatigue/Weakness ❑ Seizures ❑ Metal Slivers in Eyes

❑ Heart Problems ❑ High Blood Pressure ❑ Renal Disease ❑ Other____________________

❑ 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) _________________________________________________________________________

Chemotherapy YES NO Date of last chemo ________________________________________

Radiation Therapy YES NO Date of last radiation ______________________________________

Previous Surgeries /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

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OFFICE USE ONLY:

Contrast and Amount _____________________________________________ Time of inject________________

Technologist Signature __________________________________________________________________________

Revised: 01/2016