

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 _____