Anne Arundel
Diagnostics Imaging

CT HISTORY

Patient Name: ________________________________ Date:____________________

Symptoms related to today's exam:____

Did you drink oral contrast for today's exam? ☐Yes ☐No

Have you ever been diagnosed with cancer? ☐Yes ☐No

If yes, what type? _______________________________

Did you have Radiation Therapy? ☐Yes ☐No

Did you have Chemotherapy? ☐Yes ☐No

Surgical History- Please check all that apply

☐Sinus

☐Brain

☐Lung

☐Heart

☐Kidney ☐Right ☐Left

☐Gallbladder

☐Colon

☐Appendectomy

☐Hysterectomy

☐Bladder

☐Prostate

☐Hernia Repair

☐Cervical Spine

☐Thoracic Spine

☐Lumbar Spine

☐Vascular

☐Breast ☐Right ☐Left

☐Other________________