FIRST DAYTON CYBERKNIFE
855-DAYTON1

PATIENT HISTORY FORM- CT SCAN

Fax: 937-293-6573 NPI#1487641585

NAME:_____ DOB:_____ DATE:_____

CT EXAM TO BE DONE: □ HEAD/NECK □ CHEST □ ABDOMEN/PELVIS □ EXTREMITY

HAVE YOU HAD THIS TYPE OF SCAN BEFORE: □ YES □ NO , IF YES WHERE:_____

HAVE YOU HAD A CT SCAN WITH CONTRAST BEFORE: □ YES □ NO

IF YES DID YOU HAVE ANY ADVERSE REACTION: □ YES □ NO, EXPLAIN:_____

PLEASE LIST ALL ALLERGIES:_____

EXPLAIN THE REASON FOR THE EXAM:_____

PLEASE CHECK ALL OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

□ ASTHMA □ RESPIRTORY DISEASE □ HEMOLYTIC ANEMIA □ SICKLE CELL ANEMIA
□ KIDNEY DISEASE □ KIDNEY TRANSPLANT □ LUPUS □ MULTIPLE MYELOMA
□ HYPERURICEMIA □ HYPERTENSION □ HEART DISEASE □ DIABETES
□ LIVER DISEASE □ BREAST FEEDING PREGNANT: YES □ NO □ POSSIBLY □

IF ANY APPLY ABOVE PLEASE SPECIFY:_____

HAVE YOU HAD SURGERY BEFORE: □ YES □ NO, IF YES PLEASE LIST BELOW: (use back for additional surgeries)

TYPE OF SURGERY	YEAR

PLEASE LIST CURRENT MEDICATIONS BELOW: (use back of form for additional medications)

NAME	DOSE	FREQUENCY

I attest that the above information is correct to the best of my knowledge. I understand that there is an inherent risk with any diagnostic imaging involving radiation and I have had the opportunity to ask questions regarding the procedure I am about to undergo. I understand that I must disclose if I may be pregnant as this test may be harmful to my unborn child. I give consent for this procedure.

Signature of Patient: _____ ***Date:*** _____

OFFICIAL USE ONLY			
□ NECK :	CONTRAST: Y N	OPTIRAY	IV INSERTION REQUIRED: Y N
□ CHEST:	TYPE: IV ORAL RECTAL	300 320 350	GAUGE: 18 20 22
□ ABDOMEN:	BUN:	VOLUME:	ATTEMPTS:
□ PELVIS:	CR:	INJECTION RATE:	PERFORMED BY:
□ EXTREMITY/SPINE:	GFR:	TOLERATED WELL: Y N	TOLERATED WELL: Y N