7345 Medical Center Dr., Ste. 130
West Hills, CA 91307
phone: 818.710.6011
fax: 818.710.6311

PROHEALTH
Advanced Imaging

www.prohealthscan.com

10767 Riverside Dr.
North Hollywood, CA 91602
phone: 818.301.6700
fax: 818.301.6701

CT SCAN PATIENT CLINICAL HISTORY SHEET

Name: ______________________________ Date: ______/______/______

Date of Birth: ______/______/______ Age: __________ Weight: __________ Sex: __________

Referring Physician: ______________________ Tel: ( ) ________ - __________

Diagnosis: ______________________________

Medical History: ______________________________

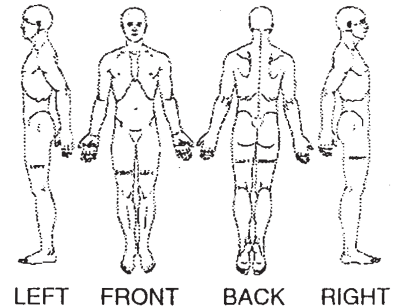
Reasons for test (major complaint): ______________________________

List any past surgeries: ______________________________

REASON FOR PROCEDURE:

Please check any of the following symptoms that you are experiencing:

- ☐ Cancer – Type ______________ ☐ Liver Disease
- ☐ Chest Pain ☐ Headaches ☐ Nausea ☐ Hearing Loss
- ☐ Weight Loss
- ☐ Seizures ☐ Blackouts ☐ Blurred Vision ☐ Ringing in ears
- ☐ Pelvic Pain ☐ Dizziness ☐ Memory Loss ☐ Abdominal Pain
- ☐ Back Pain ☐ Neck Pain ☐ Unexpected weight loss
- ☐ Shoulder Pain – (☐ Right / ☐ Left) ☐ Numbness – (☐ Right / ☐ Left)
- ☐ Leg Pain – (☐ Right / ☐ Left) ☐ Weakness – (☐ Right / ☐ Left)
- ☐ Arm Pain – (☐ Right / ☐ Left) ☐ Other: ______________



Please identify the location of any pain/numbness/lump

How and when did these symptoms occur (e.g., injury, just started, etc.)?

____

Have you ever had a CT, MRI, Ultrasound Scan of this area before? ☐ YES ☐ NO

If yes, when? ______________________________

Where was the scan performed? ______________________________

Alergies: ______________________________

Do you have Asthma?	☐ Yes	☐ No	Are you taking Glucophage?	☐ Yes	☐ No
Kidney disease?	☐ Yes	☐ No			
Are you pregnant?	☐ Yes	☐ No	Are you taking Metformin?	☐ Yes	☐ No
Are you breast feeding?	☐ Yes	☐ No			
Are you diabetic?	☐ Yes	☐ No	Are you taking Avandamet?	☐ Yes	☐ No
Multiple myeloma?	☐ Yes	☐ No			

Have you had a Barium study in the past two weeks? ☐ Yes ☐ No

Technologist Notes: ______________________________

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