DOCTORS GROOVER CHRISTIE & MERRITT

RADIOLOGISTS

Advancing Medical Imaging Since 1916

CT SCAN INFORMATION

Name: ______________________________ Date: ____________________

Age: _____ Referring Doctor: ____________________ X-Ray #:____________________

PLEASE ANSWER THE FOLLOWING QUESTIONS:

What are your present complaints? Why did your doctor send you for a CT scan? ____________________

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Do these complaints result from injury? Yes____ No ____

Date of injury: ____________________

Nature of injury: ____________________

Have you had a CT scan before? Yes ___ No ___ Exam Type ____________________

Location and date of previous CT scans: ____________________

Have you had any other diagnostic studies for your present condition? Yes ___ No ____

Exam type: ____________________ What were the results? ____________________

____

Have you had any previous surgery? Yes ___ No ___ If yes, what type? ____________________

____

Do you have any surgery scheduled? Yes ___ No ___ If yes, what type? ____________________

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Do you have, or have you ever had, any type of cancer? Yes ____ No ____ If yes, what type?

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Have you had any chemo or radiation therapy? Yes ____ No ____ When? ____________

Please explain if there is anything related to your condition that you would like us to know:

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