Health History

Patient's name			Today's Date
Age	Date of Birth		Male ☐ Female ☐
Primary Care Doctor		Physician's Phone #	Date of Last Physical Exam

1. Do you have any current health concerns?_____
2. Have you been diagnosed or have been treated for cancer in the last year? _____
3. Do you have any previously diagnosed conditions? YES / NO If yes, what radiologic studies have you had? CT, MRI, Ultrasound _____
4. Do you smoke?_____ If yes, how many years?_____If no, did you ever?_____ If yes, how long did you smoke?_____ Do you drink alcohol? _____
5. Check if your work exposes you the following: Heavy Lifting____ Hazardous substance (ie: Asbestos)_____other_____
6. Have you ever had cardiac surgery or stent placements?_____
7. Other surgical procedures?_____
8. Female Patients: Is there any possibility that you may be pregnant?_____

Family History

FAMILY MEMBER	AGE	Please list any disease or condition below:
Siblings_____	____	_____
_____	____	_____
Father	____	_____
Mother	____	_____
Grandmother	____	_____
Grandfather	____	_____

Conditions

Circle the conditions you currently have or have been treated for:

ANGINA
ARTHRITIS
ASBESTOSIS
ASTHMA
BACK/DISC DISEASE
BLADDER DISEASE
BREAST DISEASE
BRONCHITIS
CANCER (TYPE):
CIRRHOSIS
COLITIS
CONGESTIVE HEART FAILURE
DIABETES
DIVERTICULITIS
EMPHYSEMA
EPILEPSY
GOITER/THYROID DISEASE
HEART ATTACK
HEMORRHOIDS
HIGH BLOOD PRESSURE
HIGH CHOLESTEROL
KIDNEY DISEASE
LEUKEMIA
LIVER DISEASE
MIGRAINE HEADACHES
MULTIPLE SCLEROSIS
OBESITY
PACEMAKER
PNEUMONIA
PROSTATE PROBLEMS
RECTAL BLEEDING
RECTAL POLYPS
SEIZURES
STROKE
TUBERCULOSIS
ULCERS (STOMACH/BOWEL)
OTHER

Please note this study is done as a screen. This screening does not substitute for your physician's diagnostic studies nor does it preclude further diagnostic work-up should symptoms arise.

Radiologist approving scan_____Radiologic Technologist _____

Patient Signature _____