Maximum
Resolution Imaging
THE NEW ERA OF IMAGING
www.maxresolutionimaging.com

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CT without Contrast History and Screening Form

Patient Name _____
Date _____
Date of Birth _____ Age _____
Weight _____ Sex Male / Female

What is the reason for the CT today?
_____
_____
_____

Have you had any previous X-Rays, MRIs, CTs, or Ultrasounds? Yes / No
If yes : What _____
When_____ Where_____

Please answer the following:
Do you have history of Cancer? Yes / No
If yes, what type? _____
Radiation therapy? Yes / No Chemotherapy?: Yes / No

For Female patients:
Are you pregnant? Yes / No
Date of last menstrual period: _____
Are you currently breast feeding? Yes / No
List all previous surgeries:
_____
_____
_____

List all medications you take regularly:
_____
_____
_____

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I HAVE READ AND UNDERSTAND THE ENTIRE CONTENT OF THIS FORM AND I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS REGARDING THE INFORMATION ON THIS FORM.

Signature: _____ Date: _____

Stop Here- To be completed by the technologist

Technologist_____

Reason for exam
_____
Pertinent history
_____
_____