



Bannockburn • Gurnee • Libertyville  
(847) 566-1GRC

### C.T. INFORMATION SHEET

PATIENT'S NAME: \_\_\_\_\_

AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ (If female, date at last menstrual period: \_\_\_\_\_ )

TYPE OF CT EXAM: \_\_\_\_\_

PLEASE DESCRIBE YOUR SYMPTOMS: \_\_\_\_\_

\_\_\_\_\_

HAVE YOU HAD A CT SCAN BEFORE? \_\_\_\_\_

IF SO, WHERE? \_\_\_\_\_

RESULTS (if known): \_\_\_\_\_

\_\_\_\_\_

HAVE YOU HAD ANY RELATED X-RAYS, MRI, ULTRASOUND, OR NUCLEAR MEDICINE SCANS BEFORE? \_\_\_\_\_

IF SO, WHERE? \_\_\_\_\_ WHEN? \_\_\_\_\_

RESULTS (if known): \_\_\_\_\_

PLEASE LIST ANY PREVIOUS SURGERIES:

**TYPE OF SURGERY**

**DATE OF SURGERY**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DAILY MEDICATIONS: \_\_\_\_\_

LIST ANY ALLERGIES TO MEDICATIONS AND/OR FOODS: \_\_\_\_\_

\_\_\_\_\_

Have you been given "Dye" in an X-ray Department? \_\_\_\_\_

If yes, any reaction? \_\_\_\_\_

Do you have any medical problems? (Please check)

Heart Disease \_\_\_\_\_ Hypertension \_\_\_\_\_ Kidney Disease \_\_\_\_\_ Diabetes \_\_\_\_\_ HIV \_\_\_\_\_

BUN \_\_\_\_\_ Creatinine \_\_\_\_\_

**ANY POSSIBILITY OF PREGNANCY: YES NO**