



B.U.N: _____ CREATININE: _____ DATE: _____

CT PATIENT HISTORY

Patient Name: _____ DOB: _____ Weight: _____

E-mail Address _____ Cell Phone: _____

Your exam, (images and report), will automatically be sent to your Oregon Clinic Doctor

Please provide the name of your current Primary Care Physician _____

Would like today's Exam Report sent to another doctor? YES NO

If yes, please provide the physicians name and address:

Name: _____

Address: _____

CIRCLE YOUR ANSWER:

Are you pregnant? YES NO

Any thyroid treatments: Past, Present, or Future? YES NO

Do you have a history of smoking? YES NO

If yes, when did you quit? _____ How many years did you smoke? ___ packs per day? ____

What symptoms are you experiencing now? _____

Any personal history of cancer? YES NO

If yes, when were you diagnosed, where was it located, and what were the treatments?

DATE LOCATION TREATMENTS

Have you had a prior CT scan? YES NO

DATE WHERE WAS IT DONE WHAT KIND

Have you ever had surgery? YES NO

DATE WHERE WAS IT DONE WHAT KIND

TO BE COMPLETED BY THE OREGON CLINIC STAFF

IV contrast given _____ ML _____ Tech's initials _____

Scan details: FOV _____ Size _____ Scan specifics _____