Health Village Imaging

A Member of the Hackensack Meridian Health Network

PATIENT NAME: ____________________________________**DATE OF BIRTH**: ____________________

Why are you having this scan today? ____

Any prior tests that pertain to the reason you are having this test?___________________________________

Height ___________ Weight ___________

MEDICAL HISTORY (Please circle all that apply)

Cancer_______________	Diabetes	Kidney/Renal Disease
Chemotherapy	Hypertension	Multiple Myeloma
Radiation Therapy	Asthma	Sickle Cell
COPD/Emphysema	Hyperthyroidism	Myasthenia Gravis
History of Smoking	Stroke	Polycythemia Vera

Please give date and type of **any** surgery:

____

____

Please list any allergies to food or drugs (i.e. **Iodine/Iodine Contrast**):

____

Please list any medications you are taking:

____

____

Any possibility of pregnancy? **Yes** **No** **Don't know** Are you breast feeding? **Yes** **No**

First date of last menstrual period? ________________________

Signing below indicates that you have read and understand this form and have completed it to the best of your ability.

Patient or Legal Representative Signature ____

Technologist Signature____Date_____________

REV 9-2024
CT FORM