

# Patient Personal History- CT CORONARY

NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_ REFERRING DOCTOR \_\_\_\_\_

REASON YOU ARE HERE: \_\_\_\_\_

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

MEDICATION ALLERGIES: \_\_\_\_\_

## MEDICAL HISTORY:

HEART TROUBLE	DIABETES	ARTHRITIS	HIGH BLOOD PRESSURE
THYROID TROUBLE	ASTHMA	EMPHYSEMA	HIGH CHOLESTEROL
HEPATITIS	STROKE	CANCER	STOMACH TROUBLE

SURGERIES: \_\_\_\_\_

## PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU ARE EXPERIENCING:

WEAKNESS	CHEST PAIN	FEVER	ABDOMINAL PAIN
COUGH	CONSTIPATION	RASH	WEIGHT LOSS/ GAIN
SHORTNESS OF BREATH	DIARRHEA	NAUSEA	BLACK /BLOODY STOOL
PALPITATIONS	VOMITING	SWELLING	TROUBLE URINATING
HEADACHES	NUMBNESS	DIZZINESS	INDIGESTION
TINGLING	VISION CHANGES	HEART BURN	JOINT PAIN

OCCUPATION: \_\_\_\_\_

HAVE YOU EVER USED TOBACCO? YES NO TYPE: CIGARETTES CIGAR PIPE CHEW DIP

AMOUNT PER DAY \_\_\_\_\_ HOW LONG? \_\_\_\_\_ IF STOPPED WHEN \_\_\_\_\_

ALCOHOL USE: YES NO AMOUNT: \_\_\_\_\_ CAFFEINE USE: YES NO AMOUNT: \_\_\_\_\_

ARE YOU ALLERGIC TO IODINE: YES NO LAST MENSTRAL CYCLE: \_\_\_\_\_

## TECH INFORMATION:

PT WEIGHT: \_\_\_\_\_ PT HEIGHT: \_\_\_\_\_ TECHNOLOGIST: \_\_\_\_\_

### **PRE SCREENING INFORMATION:**

BLOOD PRESSURE: \_\_\_\_\_

HEART RATE: \_\_\_\_\_

O2 SAT: \_\_\_\_\_

### **POST SCREENING INFORMATION:**

BLOOD PRESSURE: \_\_\_\_\_

HEART RATE: \_\_\_\_\_

O2 SAT: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_