RHODE ISLAND
MEDICAL IMAGING

CT and MRI Patient Clinical History Sheet

Date: _____

Patient Name:

DOB: **MRN:**

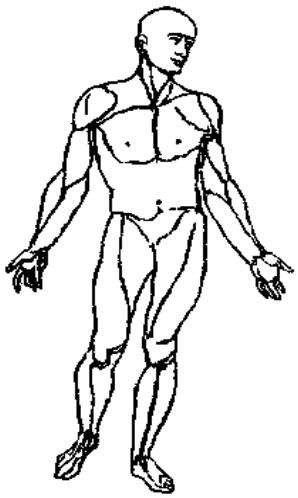
Have you confirmed patients name and DOB?

☐ _____

Please mark the areas of your pain or problem on the diagram.
(You may pick more than one.)

Area of Concern

Right



Left

Circle the Areas of Concern.

Brain: Brain Eyes Ears Pituitary

Spine: Neck Upper Back Lower Back

Chest: Lungs Heart/Cardiac

Abdomen: Liver Pancreas Kidneys

Pelvis: Uterus Ovaries Prostate

Orthopedic Study:

Shoulder Elbow Wrist Hand
Hip Knee Ankle Foot

Blood Vessels:

Brain Neck Chest Abdomen Extremities

Please answer the questions below to the best of your ability. These are meant to assist our radiologists as they review your study.

Please explain your symptoms: _____

When/how did this problem develop? _____

Did you ever have any type of surgery on the area being scanned today? ( ) Yes ( ) No

If yes, what type of surgery & when? _____

Have you had any history of any type of cancer? ( ) Yes ( ) No

If yes, what type of cancer? _____

When & what therapy have you had? _____

Have you ever had a CT or MRI scan of this area before? ( ) Yes ( ) No

If yes, when was the CT or MRI performed? _____

Where was the exam performed? _____

For Female patients, are you pregnant possibly pregnant or breast feeding? _____

If you are having a CT Scan today, please answer the following questions.

Cigarette smoking: ☐never smoked ☐still smoke ☐quit: how long ago_____

If smoked, how many packs per day?_____ For how long?_____