REAGAN DIAGNOSTICS

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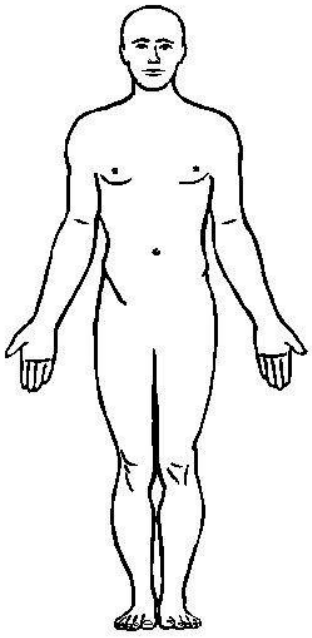
CT SCAN SCREENING FORM

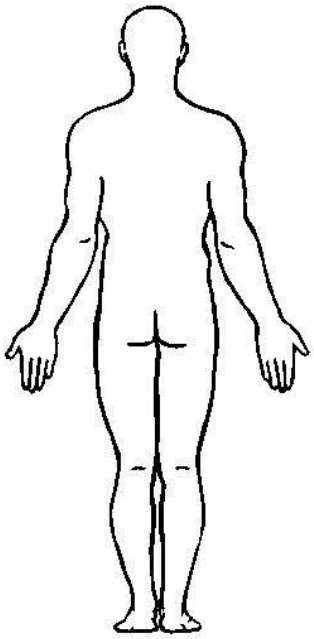
Patient Name: _____ Date:_____

Please answer the questions below to the best of your ability. These are meant to assist our Radiologists as they interpret your exam.
Please shade the area of your symptoms and area(s) of concern on this diagram. You may choose more than one.



Area(s) of concern

Head
Neck
Chest
Abdomen
Pelvis
Spine
Arm
Elbow
Wrist / Hand
Hip / Leg / Knee
Foot / Ankle



Please describe your symptoms: _____

When did your problem develop?_____ __ What do you think your diagnosis is? _____

Do you have a history of cancer? _____ If yes, what type and what therapy? _____

Do you smoke? _____ Did you ever have any type of surgery on the area being scanned today? ☐Yes ☐No

If yes, what type of surgery _____When was the surgery? _____

Have you ever had a CT scan of this area before?☐ Yes ☐No If yes, when? _____

Where was the scan performed? _____

Signature of patient: _____