

REAGAN DIAGNOSTICS

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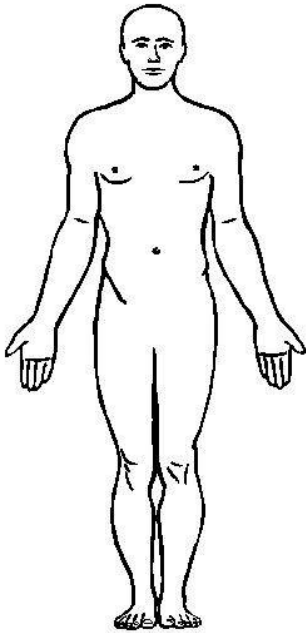


CT SCAN SCREENING FORM

Patient Name: _____ Date: _____

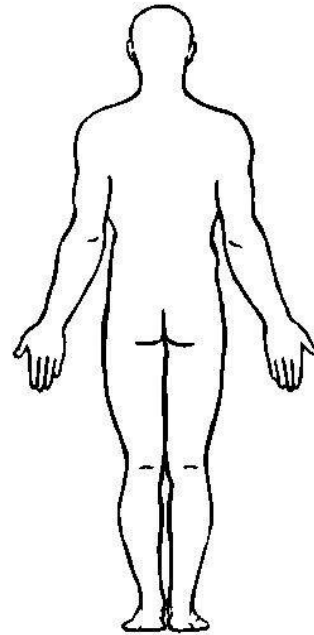
Please answer the questions below to the best of your ability. These are meant to assist our Radiologists as they interpret your exam.

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: _____