

RADIOLOGY GENERAL HISTORY FORM

Patient Name: _____ Date: _____

Referring Physician: _____

Type of Study: _____

REASON FOR EXAM (SYMPTOMS): _____

History of Cancer: YES / NO If yes, please list the type: _____

ANY KNOWN DRUG, CONTRAST OR DYE ALLERGIES? YES / NO

NAME OF DRUG

REACTION

PLEASE LIST PRIOR X-RAYS, CAT SCANS, MRI'S, ULTRASOUNDS AND NUCLEAR MEDICINE TESTS YOU HAVE HAD:

TEST PERFORMED

DATE

FACILITY

PLEASE LIST ANY SURGERIES THAT YOU HAVE HAD IN THE PAST

SURGERY

YEAR
