Southwestern Vermont Medical Center

100 Hospital Drive
Bennington, VT 05201

Medical History for CT and X-Ray Procedures

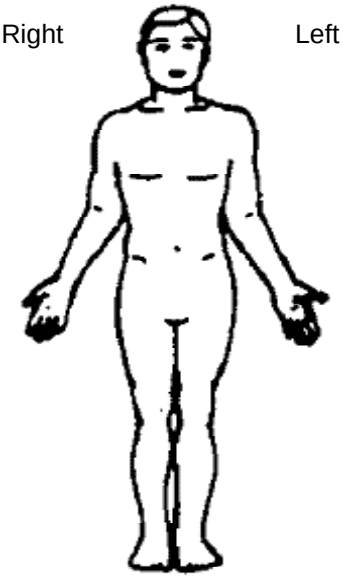
What are your current symptoms and how long have you had them?

_____

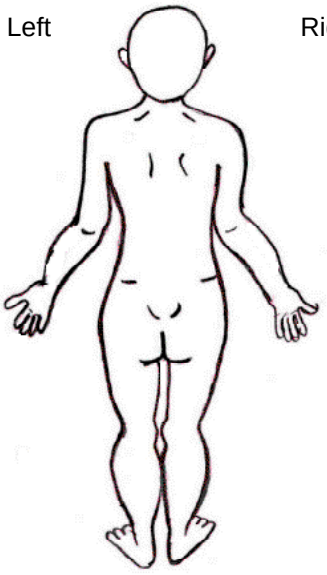
_____

Please indicate on the diagrams to the right, where your symptoms are.

Right Left



Left Right



Have you had surgery involving the area being scanned today? ☐ No ☐ Yes; type: _____

date: _____

type: _____

date: _____

Do you have a history of cancer? ☐ No ☐ Yes; please indicate where _____

Have you had previous imaging studies involving the area being scanned today? ☐ No ☐

Did you receive radiation therapy for this cancer? ☐ No ☐ Yes

Do you smoke? ☐ No ☐ Yes: # of packs/ day: _____ # of years: _____

Have you ever smoked? ☐ No ☐ Yes: # of years: _____

Is there any possibility you may be pregnant? ☐ No ☐ Yes

Are you currently breast feeding? ☐ No ☐ Yes

_____ _____

Patient signature Date Time Technologist signature Date Time

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