

Southwestern Vermont Medical Center

100 Hospital Drive
Bennington, VT 05201



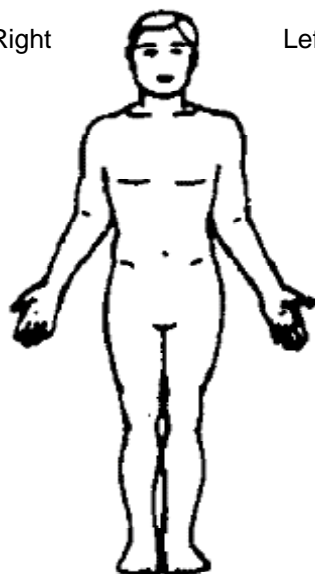
Medical History for CT and X-Ray Procedures

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

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

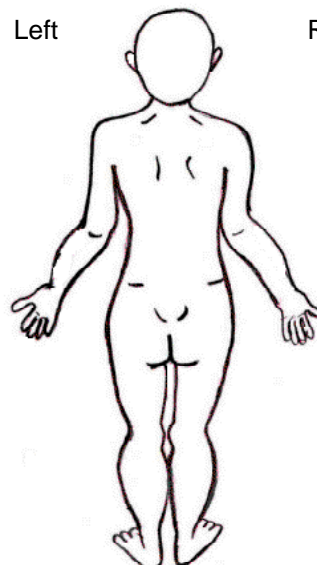
Right

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