DIAGNOSTIC IMAGING CENTERS, P.A.

CT Sinus Information

Patient Information

Name:_____Date:_____ DOB:_____ Weight:_____

What are your symptoms:_____

How long have you had symptoms:_____

Medical Information

1. Have you had prior head or sinus surgery? ☐Yes ☐No
   If yes, please indicate the type and date of head or sinus surgery:
   Type of Surgery:_____ Date:_____
   Type of Surgery:_____ Date:_____
2. Have you had a prior head or sinus examination (MRI, CT, X-ray, etc.)? ☐Yes ☐No
3. Do you have a history of cancer? If yes, explain. _____
4. Smoking status: ❑ Never ❑ Decline to answer ❑ Current ❑ Former
   If current or former smoker: how many packs per day_____ for how many years_____

Patient Signature_____ Date_____

Technologist_____ Technologist_____

For Female Patients Only

1. Date of last menstrual period: _____ Post Menopausal? ☐Yes ☐No
2. Are you pregnant or experiencing a late menstrual period? ☐Yes ☐No
3. Have you had a hysterectomy? ☐Yes ☐No
   If yes, was it a complete hysterectomy? (removal of ovaries and uterus) ☐Yes ☐No
   Date of surgery_____
4. Are you taking oral contraceptives or receiving hormonal treatment? ☐Yes ☐No
5. Are you currently breastfeeding? ☐Yes ☐No

Medical Records Release

Please sign the medical release below.
This allows our facility to obtain your previous exams or prior medical history as it pertains to today's exam.

Submitted to: _____
Name of facility

_____

_____

Patient Name:_____

Social Security #:_____ Date of Birth:_____

Type of records requested:_____

I hereby authorize and request you to release the complete medical records mentioned above, including copies of the reports in your possession to Diagnostic Imaging Centers, PA.

_____ _____
Patient or Authorized Person Date