HEALTHTEXAS PROVIDER NETWORK
DDA-IMAGING
CT DEPARTMENT OF RADIOLOGY

PATIENT INFORMATION FORM

Patient Name:_____ Date:_____ Age:_____

Referring Physician:_____ Sex: _____ Ht._____ Wt._____

Type of Insurance: Medicare:_____ Other:_____

PATIENT SURGICAL HISTORY DOB _____

_____Gallbladder	_____Heart Bypass	_____Spleen
_____Hysterectomy	_____Heart Valve	_____Kidney
_____Hernia	_____Back	_____Knee R L
_____Shoulder R L	_____Neck	_____Stomach
_____Appendix	_____Colon	

_____Other:_____

CLINICAL HISTORY

Patient Symptoms :_____

Onset of Symptoms:_____

Injury? _____NO _____YES- EXPLAIN:_____
Date of Injury_____

Previous Cancer? _____NO _____YES-LOCATION:_____

Prior Imaging Studies Related to Above Symptoms:

_____MRI _____ULTRASOUND
_____CT _____OTHER:_____

Please bring these films with you, if at all possible, on the day of your exam.