

**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**

**CHART#** \_\_\_\_\_

|                    |                    |                |
|--------------------|--------------------|----------------|
| _____ 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.