

CT HISTORY

Patient Name: _____ Date: _____

Additional History (current clinical concerns, symptoms):

All previous surgeries:

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Have you ever been diagnosed with cancer? Yes _____ No _____ Type: _____

Did you have Radiation Therapy? Yes _____ No _____

Did you have Chemotherapy? Yes _____ No _____

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