



MEDICAL HISTORY FORM

Be Well Body Scan 25 Boylston St. (Route 9) Chestnut Hill, MA
www.BeWellBodyScan.com 1-877-263-9287

Name _____ Age _____ Gender M F
Height _____ Weight _____

● PRIOR CT SCAN

Have you ever had a CT scan before? Y N

If so, when? For what purpose? _____

● SMOKING HISTORY

Do you smoke cigarettes? Y N How many packs per day and for how many years? _____

Are you a former smoker? Y N If so, when did you quit? _____

How many packs per day and for how many years? _____

● FAMILY HISTORY

Do/did any of your parents or siblings have any of the following? (please check all that apply):

- Heart disease Lung Disease Diabetes
- Cancer Kidney Disease Osteoporosis

If cancer – who, and what type? _____

● PERSONAL HISTORY

Have you ever had any of the following? (please check all that apply):

- Thyroid disease Lung disease Heart disease Diabetes
- High Cholesterol Liver disease Gall stones Kidney disease
- Aneurysms Pancreas disease Bowel disorders Osteoporosis
- High Blood Pressure (Hypertension)

Have you ever been treated for the following cancers? (please check all that apply):

- Thyroid Lung Liver
- Kidney Pancreas Colon
- Breast Prostate Lymphoma or Leukemia

Have you ever had surgery? Y N

If so – what type and when? _____

Do you take any medications on a regular basis? Y N

Please List: _____

When was the last time you saw a doctor? _____

Please list any concerns you would like to discuss with the radiologist:

