CT QUESTIONNAIRE

Date ___________________________ Height ______________

Name ___________________________ Weight ______________

Referring Physician ________________________________________________

Pt. complaint/problem ______________________________________________

____________________________________________________________________

Have you ever had this exam? YES  NO  If yes, where? ________________________________

Have you had other previous x-rays or scans of the area of interest? YES  NO  If yes, where? 

____________________________________________________________________

Please list any prior surgeries or operations you have had relating to area being scanned.

____________________________________________________________________

Have you ever had an allergic reaction to any medicine containing iodine, such as injections for kidney tests, angiograms, IVP dye, CT scans, etc? YES  NO

If yes, please explain:

____________________________________________________________________

Please check if you have any of the following.

High Blood Pressure _____  Multiple Myeloma _____  Lupus _____
Diabetes _____  Kidney Disease _____  One Kidney _____
Heart Disease _____  Cancer _____  Angina _____
Sickle Cell Anemia _____  Are you pregnant? _____  CHF _____
Asthma _____  Nursing _____  Heart attack _____
Arrhythmia _____

If you take any of these medications please circle all that apply.

Glucophage, Glucovance, Metformin, Glybemetformin, Metaglip, Avandement, Avandamet

List other medications

____________________________________________________________________

Do you, or have you smoked cigarettes? Yes  No  If yes, how many packs per day and for how many years? ______ Pack per day _____ years. If you quit, how long ago? ________________

Technologist use: LAB WORK DATE: _________  BUN _________  CREAT _________