CT QUESTIONAIRE

DATE: _____ **PATIENT NAME :** _____

DOB: _____ **AGE:** _____ **WEIGHT:** _____ **GENDER:** **MALE / FEMALE**

PLEASE COMPLETE THE FOLLOWING QUESTIONAIRE

1. **Why has your physician sent you for a CT Scan?** _____

2. **Do You Have Any Allergies:** ☐ No ☐ Yes— If yes, list: _____

_____

3. **Any Previous Adverse Reaction to Contrast Material:** ☐ No ☐ Yes — If yes, list: _____

_____

Have You Ever Had A Severe Life Threatening or Anaphylactic Reaction to Food, Medication, or Insect or Bug Bites?

☐ No ☐ Yes— If yes, list: _____

Medical History:

1. Have you ever been diagnosed with the following? **(Please Check)**

____ Diabetes If diabetic, do you take: Glucophage, Metaformin, Glucovance? ☐ No ☐ Yes— If yes:
When was your last dose?_____ **When is your next dose?** _____

____ Kidney Dysfunction If Kidney Dysfunction, are you on dialysis? ☐ No ☐ Yes— If yes:
When is your next session?_____

____ High Blood Pressure ____ Lung Disease ____ Heart Disease ____ Asthma

2. Have you ever been diagnosed with cancer or serious illness? ☐ No ☐ Yes— If yes:

Chemo Therapy ☐ No ☐ Yes, When**?**_____ **Radiation Therapy** ☐ No ☐ Yes, When**?**_____

3. List any over the counter or prescription medications you are taking:_____

_____

PREGNANCY STATEMENT

(Diagnostic Radiology procedures have the possibility of endangering an unborn child at any stage of pregnancy .
In order to avoid exposure to an unborn fetus, we must ask the questions noted on this form in regards to pregnancy, no matter how remote the possibility).

4. Currently Pregnant: ☐ No ☐ Yes Date of your last menstrual period? _____

5. Would you like a copy of the "Patient's Bill Of Rights and Responsibilities"? □ No □ Yes

I attest that the answers I have provided to the questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Patient Signature:_____

Date: _____