

CT PATIENT QUESTIONNAIRE

Name: _____ Age: _____ Sex: _____ Weight: _____

Describe Symptoms: _____

HEAD STUDIES:

Check all that apply

- ____ Head injury
- ____ Headaches
- ____ Dizziness
- ____ Blackouts
- ____ Seizures
- ____ Previous stroke

SPINE STUDIES:

Check all that apply

- ____ Arm injury
- ____ Arm pain
- ____ Arm numbness
- ____ Leg injury
- ____ Leg pain
- ____ Leg numbness

CHEST AND ABDOMEN STUDIES:

Check all that apply

- ____ Pain
- ____ Blood in urine
- ____ Cough
- ____ Blood in stool
- ____ Smoker
- ____ Nausea or vomiting
- ____ Vomiting blood
- ____ Congestive heart failure
- ____ Possibility of pregnancy

Last menstrual period: _____

SURGICAL HISTORY:

List all surgeries: _____

List previous exams: _____

PATIENT HISTORY: *Select the appropriate answers*

- | | | | | | |
|--|-----|----|---|-----|----|
| Allergies requiring medication | Yes | No | Severe arrhythmia/Irregular heartbeat | Yes | No |
| If yes, is this prescription? | Yes | No | Heart block (2nd or 3rd degree) | Yes | No |
| Food allergies | Yes | No | Recent myocardial infarction/heart attack | Yes | No |
| Drug allergies | Yes | No | Generalized severe debilitation | Yes | No |
| Hives | Yes | No | Have you ever had cancer? | Yes | No |
| Hay fever | Yes | No | If yes, list type _____ | | |
| Asthma | Yes | No | Sickle-cell anemia | Yes | No |
| Seizures | Yes | No | Low blood count (anemia) | Yes | No |
| Unstable angina/Severe chest pain caused by lack of oxygen to the heart | | | | Yes | No |
| Pulmonary hypertension/High blood pressure in the arteries that supply the lungs | | | | Yes | No |

Have you ever been given, or are you currently receiving, radiation or chemotherapy treatments? Yes No

Date of last treatment: _____

Do you have a history of kidney problems? Yes No

If yes, please describe: _____

Do you have a history of adverse reaction to contrast material, with the exception of a sensation of heat, flushing or a single episode of nausea or vomiting? Yes No

Do you have a history of diabetes? Yes No

If yes, are you taking a medication called Glucophage, Metformin Hydrochloride, Glucovance, Avandamet or Fortamet? Yes No

IF YES, PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY

Is this procedure being done due to a work-related injury? Yes No

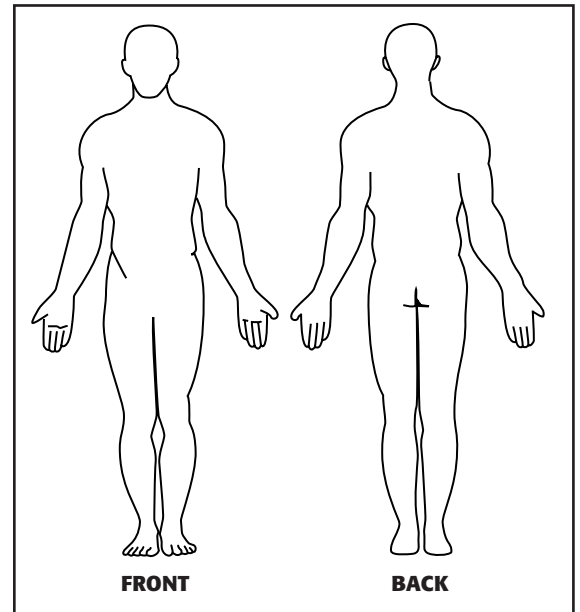
Please describe: _____

Is this procedure being done due to an automobile accident? Yes No

Please describe: _____

Signature: _____ Date: _____

I attest that the above information is correct to the best of my knowledge.



Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.).

TO BE COMPLETED BY DEPARTMENTAL STAFF

Exam: _____ Reason for exam: _____ Creatinine: _____

Contrast type: _____ Amount/RateSite: _____

Technologist: _____ Date: _____