CT Questionnaire

Patient Name: _____ Date: _____

Referring Provider: _____ Date of Birth: _____

Weight:_____ Height:_____

What problems or complaints are you having that prompted your provider to order this test? _____

_____

_____

How long have you had these symptoms? _____

Have you had any other tests related to this problem or in this area of your body? Check all that apply:

☐CT Scan ☐ MRI ☐ Ultrasound ☐ Nuclear Medicine Scan ☐ X-ray

Facility _____ Date(s): _____

Have you ever received Intravenous Contrast/X-Ray dye? Yes No

If yes, did you have an allergic reaction? Yes No

If yes, please describe the reaction: _____

Do you have or have you had in the past any of the following medical problems? (Check all that apply)

☐ Kidney problems/failure ☐COPD ☐ Urinary Tract Problems ☐ Pulmonary fibrosis
☐ Heart Attack ☐ Stroke ☐ Thyroid Problems ☐ Coronary Artery Disease
☐ Irregular Heartbeat ☐ Hepatitis ☐ High Blood Pressure ☐ Coronary heart disease
☐ High cholesterol ☐ Emphysema ☐ Peripheral Vascular Disease
☐ Diabetic and/or on metformin/metformin containing meds
☐ Family history of heart disease? Who?_____

☐ Cancer, where? _____Date diagnosed_____ Treatment ended (date)? _____

Smoking History? YES NO
If yes, for how many years? _____ Packs per day? _____Years since you quit (If applicable)?_____

Please list any previous surgeries and/or any organs that were removed: _____

_____

Is there a possibility that you are pregnant? YES NO

For Staff Use Only:

Was the patient pre-medicated for this exam? Yes No

CTDI Vol: _____ DLP: _____

Tech Initials:_____ Account #: _____

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