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 _____