

CT PATIENT QUESTIONNAIRE

The following questions are to assure your safety and make us aware of any condition that could interfere with your CT study. Please answer all questions.

Patient Name: _____ DOB: _____ SMI ID # _____
(FOR OFFICE USE)

ATTENTION: Please answer the following questions *completely*. If you have any questions regarding your CT exam please notify the receptionist or technologist.

PLEASE CIRCLE YES OR NO TO THE FOLLOWING ITEMS:

1. Do you have diabetes? YES NO
2. Do you take Glucophage, Glucovance or Metformin? YES NO
3. Do you have kidney problems? YES NO
4. Do you have lung problems? YES NO
5. Do you have medical allergies? YES NO if yes, please list: _____

6. If you are female, is there any chance of pregnancy? YES NO
Date you started your last menstrual cycle? _____
7. Have you had a previous CT/MRI/US? YES NO if yes, when and where? _____

8. Previous surgeries? _____

9. Medical history (family and personal) pertaining to your exam: _____

10. Please provide a summary of symptoms: _____

I HAVE ANSWERED THE QUESTIONS IN THIS SECTION TO THE BEST OF MY KNOWLEDGE.

PLEASE INITIAL: _____

CONTRAST CONSENT:

Your study may have been ordered by your physician to include an intravenous contrast injection, or our radiologist may feel that after reviewing your study and/or history you need to have an intravenous contrast injection, which will be performed by one of our certified technologists under the supervision of our ACLS certified technologist or radiologist. Please sign and date below.

SIGNATURE OF CONSENT: _____ DATE: _____