



CT Patient Questionnaire and Screening for CT Contrast Usage

Patient Name _____

Date _____

Sex: M / F Age _____

Date of Birth _____

Do you have a return appointment scheduled with your doctor? Yes / No

If yes, when and where? _____

Have you had any previous studies / tests related to today's visit? Yes / No

If yes, please describe what studies / tests were done, what date the study / test was done ,and where it was done

Please describe any symptoms you have / or have had _____

Do you have a history of cancer? Yes / No If yes, what type(s) and date(s) of cancer? _____

Are you pregnant or breastfeeding? Yes / No

Do you smoke? Yes / No

Family History of Heart Disease? Yes / No

Do you have hypertension? Yes / No

Allergies: Drugs _____

 Foods _____

Any previous surgeries? Yes / No If yes, please list previous surgeries _____

Do you have now or previously had:

Congestive Heart Failure Yes / No

Heart Attack Yes / No

Chest Pain Yes / No

Asthma Yes / No

Sickle Cell Disease Yes / No

High BP / Low BP (please circle one) Yes / No

Kidney Disease / Malfunction Yes / No

Insulin Pump or any other type of pump Yes / No

Diabetic Yes / No

If yes to Diabetes what medication do you take, if any? _____

I authorize the following diagnostic procedure to be performed and I understand that this is a diagnostic procedure that does have some remote risks and I consent to the treatment.

Signature of Patient or Legal Representative

Relationship to patient

Technologist Data

BUN _____

Creatinine _____

Comments _____

Reaction Today: Yes / No

Technologist _____