CT QUESTIONNAIRE

NAME:_____ **DATE:**_____

WEIGHT:_____**FEMALE PATIENTS: PREGNANT: ☐Y ☐N BREAST FEEDING: ☐Y ☐N**

REASON FOR EXAM:_____

_____

HOW LONG HAVE YOU HAD THE ABOVE SYMPTOMS?_____

ANY PREVIOUS IMAGING OF THE BODY PART BEING EXAMINED TODAY? ☐Y ☐N

IF YES, WHERE?_____ **WHEN?**_____

PLEASE LIST ALL PRIOR SURGERIES:_____

_____

HAVE YOU EVER RECEIVED IV CONTRAST/XRAY DYE? ☐Y ☐N

IF YES, DID YOU HAVE AN ALLERGIC REACTION? ☐Y ☐N

IF YES, DESCRIBE THE REACTION:_____

DO YOU CURRENTLY HAVE OR HAVE YOU HAD A HISTORY OF:

KIDNEY DISEASE/DIALYSIS: ☐Y ☐N

LUNG DISEASE: ☐Y ☐N

HAYFEVER: ☐Y ☐N

HIVES: ☐Y ☐N

HEART DISEASE: ☐Y ☐N

MULTIPLE MYELOMA: ☐Y ☐N

SICKLE CELL DISEASE: ☐Y ☐N

SMOKING: ☐Y ☐N

CANCER: ☐Y ☐N
RADIATION/CHEMO: ☐Y ☐N
DATE OF LAST TREATMENT:_____

DIABETES: ☐Y ☐N
DO YOU TAKE ANY MEDICATIONS CONTAINING METFORMIN: ☐Y ☐N

OFFICE USE ONLY:

CONTRAST AGENT:_____ **AMOUNT INJECTED:**_____
LOT #:_____ **EXPIRATION DATE:**_____
IV SITE:_____ **NEEDLE GAUGE:** _____

PATIENT CREATININE:_____ **WAS PATIENT PRE-MEDICATED FOR EXAM? ☐Y☐N**