THE IMAGECARE CENTERS

CT SCAN QUESTIONNAIRE

Name:_____ DOB: _____

1. Why did your doctor order this scan?_____

2. Please describe any pain/discomfort you have:_____

3. Have you ever had a CT before? **YES** **NO**

   If yes, what type, when and where?_____

4. Have you ever received IV contrast (dye) before**?** **YES** **NO**

5. Do you have any **allergies** to food, medicine, NutraSweet or latex? **YES** **NO**

   If yes, what? _____

6. Are you diabetic? **YES** **NO**

   IF YES, do you take: GLUCOPHAGE , GLUCOVANCE, AVADAMET, METAGLIP, METFORMIN, ACTOPLUS-MET, JANUMET, GLUCOPHAGE X-RAY

IMPORTANT: These medications must not be taken 48 hours after your scan

Have you ever been diagnosed with cancer: **YES** **NO**

If yes, what type and when?_____

Radiation therapy: **YES** **NO** When:_____ *Chemotherapy:* **YES** **NO** When:_____

Have you ever had a major surgery? **YES** **NO**

If yes, what type and when?_____

Do you have a history of kidney disease, renal failure, renal disease, renal insufficiency, or do you have only 1 kidney? **YES** **NO**

Do you have sickle cell disease? **YES** **NO**

Do you have multiple myeloma? **YES** **NO**

Have you ever had an allergic reaction to IV contrast before? **YES** **NO**

If yes, please describe what happened?_____

Do you have any pheochromocytoma (adrenal mass)? **YES** **NO**

Do you have any major medical problem? **YES** **NO**

If yes, what?_____

FEMALE PATIENTS ONLY:

Are you pregnant?	**YES**	**NO**	Last menstrual period:_____
Are you trying to get pregnant?	**YES**	**NO**	
Are you breastfeeding?	**YES**	**NO**	
Any breast surgeries?	**YES**	**NO**	If yes, which side and when?_____
Have you had a hysterectomy?	**YES**	**NO**	If yes, when?_____

Patient Signature: _____Date:_____