CT Questionnaire

Name:_____ DOB:_____ Date: _____

1. Reason for today's exam: _____
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. Do you have any **allergies** to food, medicine, NutraSweet or latex? **YES** **NO**

   If yes, what: _____
5. Have you ever been diagnosed with cancer? **YES** **NO** If yes, what type and when? _____

   Radiation therapy: **YES** **NO** When:_____ *Chemotherapy:* **YES** **NO** When:_____
6. Have you ever had a major surgery? **YES** **NO**

   If yes, what type and when: _____
7. Do you have pheochromocytoma (adrenal mass)? **YES** **NO**
8. Do you have any major medical problems? **YES** **NO**

   If yes, what? _____

PLEASE COMPLETE IF CT IS BEING PERFORMED WITH IV CONTRAST:

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

If yes, have you ever had an allergic reaction to IV contrast before? **YES** **NO**

If yes, please describe what happened?_____

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

Do you have a history of kidney disease, renal failure/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**

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**:_____

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