ADVANCED IMAGING CONCEPTS

CT Questionnaire

Patient Name: _____Date:_____Weight:_____

Referring Physician:_____Type of Study:_____

Patients Age:_____Height:_____Smoker: Yes No Possibility of Pregnancy: Yes No

Any Personal History: COPD / ASTHMA OR EMPHYSEMA (Circle any)

History of Personal Cancer: Yes or No (If yes, list the type and the year)

Any known drug allergies: Yes or No Are you allergic to iodine? Yes or No

List all drug allergies:_____

Tell us why you are having this exam today:_____

List any exams below that pertain to the exam you are having today.
At which facility/Approximate date?

Bone Scan Yes No_____

CT Scan Yes No_____

MRI Scan Yes No_____

X-Rays Yes No_____

Ultrasound Yes No_____

Circle any of the following surgeries you have had in your lifetime:

GALLBLADDER / APPENDIX / COLON / HERNIA REPAIR / PROSTATE / LIVER

HYSTERECTOMY: Removal of Right / Left / Both ovaries (Circle one)

KIDNEY STONES: Right / Left (Circle one or both) BREAST: Right / Left (Circle one)

Other surgery not listed:_____

Remove all jewelry and personal devices prior to being brought into exam room. You are responsible for your personal belongings.

Patient Signature Date

_____

Technologist Signature Date

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