

**CT PATIENT HISTORY & QUESTIONNAIRE**

**DATE:** \_\_\_\_\_ **NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_

**REFERRING DR:** \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING: (CIRCLE YES OR NO)**

HAVE YOU EVER HAD A CT SCAN OF THE AREA THAT WE ARE SCANNING TODAY? YES NO  
 FACILITY \_\_\_\_\_ DATE \_\_\_\_\_  
 HAVE YOU EVER BEEN INJECTED WITH X-RAY DYE? YES NO  
 IF YES, DID YOU HAVE A REACTION? YES NO  
 HAVE YOU EVER HAD SURGERY ON THE AREA WE ARE SCANNING? YES NO  
 IF YES, PLEASE DESCRIBE IN DETAIL \_\_\_\_\_

**DO YOU HAVE ANY OF THE FOLLOWING? (CIRCLE YES OR NO)**

			<u>DESCRIPTION</u>
ASTHMA	YES	NO	_____
HAY FEVER	YES	NO	_____
DIABETES	YES	NO	_____
HIGH BLOOD PRESSURE	YES	NO	_____
RENAL INSUFFICIENCY	YES	NO	_____
SICKLE CELL ANEMIA	YES	NO	_____
DRUG ALLERGIES	YES	NO	_____
HISTORY OF STROKE	YES	NO	_____
HISTORY OF CANCER	YES	NO	_____
CHANCE OF PREGNANCY	YES	NO	_____
HISTORY OF SMOKING	YES	NO	_____

**CURRENT MEDICATIONS:**

\_\_\_\_\_  
 \_\_\_\_\_

**PLEASE DESCRIBE IN DETAIL YOUR SYMPTOMS:**

\_\_\_\_\_  
 \_\_\_\_\_

**PATIENT'S SIGNATURE** \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

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FOR TECHNOLOGIST USE ONLY

**EXAM -CLINICAL HISTORY:** \_\_\_\_\_

**CONTRAST:** \_\_\_\_\_ **TECH INITIALS:** \_\_\_\_\_