CT/Radiology Diagnostic Questionnaire

Patient's Weight: _____

Check any of the following health problems that you have had or now have:

☐ Asthma	☐ Diabetes	☐ Kidney disease	☐ Heart Attack
☐ Heart Disease	☐ Sickle Cell Anemia	☐ Myasthenia gravis	☐ Emphysema
☐ Congestive Heart Failure	☐ Multiple myeloma	☐ Lupus	☐ Angina

Check any of the following surgeries that you have had:

☐ Appendectomy	☐ Gallbladder	☐ Sinuses	☐ Breast
☐ Heart	☐ Lung	☐ Hysterectomy (uterus)	☐ Prostate
☐ Ovaries	☐ Stomach	☐ Kidney	☐ Urinary Bladder
☐ Hernia repair	☐ Pancreas	☐ Colon	☐ Small Intestine
		☐ Spine	☐ Thyroid

Explain in the space below why your doctor sent you to have this CT scan:

_____

_____

_____

☐ Yes	☐ No	Have you ever had previous CT or MRI scans of this part of your body? State when and where.
☐ Yes	☐ No	Have you ever had cancer? If yes, what type and when was it discovered?
☐ Yes	☐ No	Have you had radiation treatments? If yes, when was the last treatment?
☐ Yes	☐ No	Have you had chemotherapy? If yes, when was the last treatment?
☐ Yes	☐ No	Have you had a recent fever or infection? Please explain.
☐ Yes	☐ No	Have you ever been injected with X-ray contrast? (Also called "X-ray dye")?
☐ Yes	☐ No	Have you ever had a reaction to x-ray contrast? If yes, please explain what happened, and what type of contrast was used, if you remember.
☐ Yes	☐ No	Do you have any allergies? If yes, please list.
☐ Yes	☐ No	If you have diabetes, do you take *metformin* (Glucophage, Glucovance, Avandamet, Metaglip, Fortemat)?
☐ Yes	☐ No	Have you had any barium studies within the past 48 hours?
☐ Yes	☐ No	If you are a woman, is there any chance that you could be pregnant?

Source of information: ☐ Patient ☐ Family ☐ Chart ☐ Other _____

_____ _____

Patient Signature Date/Time

NOTE: THE RADIOLOGY TECHNOLOGISTS ARE NOT PERMITTED TO GIVE YOU A REPORT. THE REPORT WILL GO TO YOUR PHYSICIAN. YOUR PHYSICIAN OR OFFICE STAFF WILL SELECT THE APPROPRIATE METHOD OF COMMUNICATING THE REPORT TO YOU.

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

CT/Radiology Diagnostic Questionnaire

Name / MR # / Label

THIS SIDE TO BE COMPLETED BY RADIOLOGY TECHNOLOGIST

Technologist's notes/additional history: _____

CONTRAST ADMINISTRATION RECORD

IV contrast: _____ ml

☐ No contrast

☐ Omnipaque

☐ Other IV contrast *(specify)* _____

Creat _____ BUN _____

Billirubin _____ SGOT _____

Alk Phos _____ LDH _____

Other Labs _____

Oral contrast: ☐ Yes ☐ No

Location of IV site:
☐ Right upper extremity
☐ Left upper extremity
☐ Central Line
☐ Other *(specify)* _____

Premedications: _____

Complications: _____

Treatment of complication: _____

Instructions to patient: _____

Technologist's Signature: _____ Date/Time: _____

REPORT CALLED:

Date _____ Time _____ To _____ By _____

Name / MR # / Label