



# CT SCAN PATIENT QUESTIONNAIRE

Please answer the questions to the best of your ability and review any questions left unanswered with the technologist

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Approx. Weight: \_\_\_\_\_ lbs

1) Is there any chance of pregnancy? \_\_\_ Yes \_\_\_ No Date of last menstrual period: \_\_\_\_\_

2) Have you had any previous contrast studies within the past couple of days? \_\_\_ Yes \_\_\_ No

3) Have you had any reactions to a contrast dye? \_\_\_ Yes \_\_\_ No  
If yes, what reaction occurred: \_\_\_\_\_

4) Do you have any allergies to medication? \_\_\_ Yes \_\_\_ No  
If yes, please list: \_\_\_\_\_

5) Do you have any of the following medical conditions?

Asthma	___ Yes	___ No
Diabetes	___ Yes	___ No
High blood pressure	___ Yes	___ No
Heart disease	___ Yes	___ No
Kidney disease	___ Yes	___ No
Multiple myeloma	___ Yes	___ No

6) Body part being scanned: \_\_\_\_\_

7) Reason for CT Scan/symptoms you are experiencing: \_\_\_\_\_  
\_\_\_\_\_

8) Location of symptoms: \_\_\_\_\_

9) Have you had any previous testing done of the area being scanned today?

MRI	When _____	Where _____
CT Scan	When _____	Where _____
Ultrasound	When _____	Where _____
X-Ray	When _____	Where _____

10) Have you had any previous surgeries to the area being scanned? \_\_\_ Yes \_\_\_ No  
If yes what type of surgery? \_\_\_\_\_

11) Are you taking the drug Glucophage for the treatment of diabetes? \_\_\_ Yes \_\_\_ No  
If yes, when did you take the last dose? \_\_\_\_\_

12) IF YES, DID YOU INFORM THE TECHNOLOGIST OR RECEPTIONIST THAT YOU ARE TAKING GLUCOPHAGE?  
\_\_\_ Yes \_\_\_ No

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_