

**CT HISTORY QUESTIONNAIRE**

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| **THIS SECTION TO BE COMPLETED BY PATIENT** | | | | | | | | | | | | |
| **NAME:** | | | | | **DOB:** |  | | | **HEIGHT:** |  | **WEIGHT:** |  |
| Have you ever had surgery of any kind? | | | Yes | | No | | | | | | | |
| If yes, please list them **ALL**: | | | | | | | | | | | | |
| Have you ever been diagnosed with cancer? | | | Yes | | No | | | | | | | |
| If yes, please explain: | | | | | | | | | | | | |
| Are you pregnant or possibly pregnant? | | | Yes | | No Date of last menstrual cycle: | | | | | | | |
| Do you have any other allergies to food, medicine, etc?  If yes, please explain: | | | Yes | | No | | | | | | | |
| **Do you have any of the following:** | | | | | | | | | | | | |
| Kidney disease or renal failure | | | Yes | | No | | **SAME DAY iSTAT RESULTS**  **LEAVE THIS AREA BLANK**  **SPACE USED BY TECHNOLOGIST** | | | | | |
| Diabetes | | | Yes | | No | |
| Sickle Cell anemia | | | Yes | | No | |
| High blood pressure | | | Yes | | No | |
| Pheochromocytoma (adrenal gland tumor) | | | Yes | | No | |
| Multiple myeloma (tumor in bone marrow) | | | Yes | | No | |
| **FOR CONTRAST EXAMS ONLY** | | | | | | |
| As part of your exam, your doctor or radiologist may deem it advisable to administer an intravenous injection of a contrast agent to more accurately diagnose your condition. | | | | | | |
| NPO Status (last time you ate or drank): | | | | | | |
| Have you ever had a previous allergic reaction to contrast or “dye” injected for a CT Scan or cardiac catheterization? | | | Yes | | No | |
| **Prior to receiving IV contrast, ALL patients over age 40 require a creatinine level taken within the last 30 days.** | | | | | | |
| Have you had blood drawn at an outside facility within the last 30 days?  If yes, where: | | | Yes | | No | |
| **Patient or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | **Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
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| **THIS SECTION IS TO BE COMPLETED BY CT TECHNOLOGIST:** | | | | | | | | | | | | |
| Why did the doctor order the CT scan? | | | | | | | | | | | | |
| How long has this been going on? | | | | | | | | | | | | |
| Any recent accidents or injuries? | | Yes | | No | | | | | | | | |
| If yes, please explain: | | | | | | | | | | | | |
| Have you had any other tests of the same area? | X-Ray  US MRI CT Other: | | | | | | | | | | | |
| If yes to one of the above, where/when? | | | | | | | | | | | | |
| **MDI Technologist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |

6/26/18