Dakota RADIOLOGY

CT Patient Questionnaire

Name: _____ Exam: _____

DOB_____ Height _____ Weight _____

Please list your current symptoms/ medical history relating to this scan (i.e. the reason for this study):

_____

Any chance of pregnancy? ❑ Yes ❑ No

Breastfeeding? ❑ Yes ❑ No

Have you had any surgery in the area being scanned? ❑ Yes ❑ No

If yes, what? _____

Do you have a history of cancer, leukemia or lymphoma?

❑ Yes ❑ No

If yes, what kind? _____

Have you had any previous related exams to the scan being performed today?

❑ Yes ❑ No If yes, what exam? _____

where were these performed? _____

Date_____

Do you have allergies? ❑ Yes ❑ No If yes, what: _____

Have you had IV contrast before? ❑ Yes ❑ No

If yes, did you have an adverse reaction to the contrast? ❑ Yes ❑ No

If yes, explain: _____

Are you diabetic? ❑ Yes ❑ No

If yes, what diabetic medications do you take?_____

Do you have any kidney problems? ❑ Yes ❑ No If yes, explain:_____

Have you had blood drawn in the last 60 days? ❑ Yes ❑ No Facility:_____

Do you have a history of heart disease, congestive heart failure, or irregular heartbeat? ❑ Yes ❑ No

Do you have asthma? ❑ Yes ❑ No

Do you have hypertension? ❑ Yes ❑ No

I certify that I have read and understood the questions asked in this questionnaire and that the above responses are true and correct to the best of my knowledge.

_____ _____

Patient or Legal Representative Signature Date

Print Name and Authority (if legal representative)

_____ _____

Physician / Technologist Print Name Date