

Patient Name _____ Date _____

Reason for Exam _____

CT ABDOMEN & PELVIS

YES NO

- ___ ___ Could you currently be pregnant?
- ___ ___ Do you have any abdominal or pelvic pain?
Please specify _____
- ___ ___ Does your doctor suspect an infection in your abdomen or pelvis?
- ___ ___ Have you had abdominal or pelvic surgery?
- ___ ___ Does your doctor feel a mass in your abdomen or pelvis?
Please specify _____
- ___ ___ Do you have blood in your urine or your stool?
- ___ ___ History of cancer?
Please specify _____
- ___ ___ Have you had any radiation or chemotherapy? (Circle)

CT SPINE

YES NO

- ___ ___ Could you currently be pregnant?
- ___ ___ Do you have pain in your legs? Left or Right
- ___ ___ Do you have numbness in your legs? Left or Right
If yes, how far does pain/numbness go?
- ___ ___ Do you have pain in your arms or hands? Left or Right
- ___ ___ Do you have numbness in your arms or hands?
- ___ ___ Do you have pain in your back or neck?
If yes, where? _____
- ___ ___ Have you had any injury to your back?
If yes, when? _____
- ___ ___ Have you had any form of cancer?
Please specify _____
- ___ ___ Have you had any surgery on your back or neck?
Please specify _____

CT EXTREMITY

YES NO

- ___ ___ Could you currently be pregnant?
- ___ ___ Have you had an injury to the area of concern?
Please specify _____
- ___ ___ Do you have pain?
Please specify _____
- ___ ___ Does your doctor feel a mass?
Please specify _____
- ___ ___ Have you had surgery in this area?
Please specify _____
- ___ ___ Have you had any form of cancer?
Please specify _____
- ___ ___ Do you have any form of arthritis?
Please specify _____

Please circle any of the following tests done:

CAT SCAN Where was test performed? _____

MRI Where was test performed? _____

X-RAYS Where was test performed? _____

CT CHEST

YES NO

- ___ ___ Could you currently be pregnant?
- ___ ___ Emphysema?
- ___ ___ Chronic Bronchitis?
- ___ ___ Trouble swallowing food or liquid?
- ___ ___ Repeated chest pain?
- ___ ___ Persistent cough that produced sputum?
- ___ ___ A cough that produced blood?
- ___ ___ Surgery on your chest?
- ___ ___ Abnormal chest x-ray?
- ___ ___ History of cancer? Specify _____
- ___ ___ Have you had any radiation or chemotherapy? (Circle)

SMOKING HISTORY

YES NO

- ___ ___ Have you ever smoked cigarettes regularly?
How much did you smoke? _____
- ___ ___ If you stopped smoking, when did you stop? _____
- ___ ___ Did you ever smoke cigars or pipes regularly?

Please turn over and complete

CT ORBITS/FACIAL BONES/SINUSES/NECK

YES NO

- ___ ___ Could you currently be pregnant?
- ___ ___ Do you have any pain in your neck or facial area?
Please specify _____
- ___ ___ Do you have chronic sinusitis (sinus infections)?
- ___ ___ Does your doctor suspect you have an infection?
- ___ ___ Do you have any swelling in your neck?
Please specify _____
- ___ ___ Do you have difficulty swallowing?
- ___ ___ Have you had any injury to your neck or facial area?
Please specify _____
- ___ ___ Have you had any form of cancer?
Please specify _____
- ___ ___ Have you had any radiation or chemotherapy (Circle)

CT BRAIN

YES NO

- ___ ___ Could you currently be pregnant?
- ___ ___ Have you had any recent injury to your head?
- ___ ___ Do you have headaches?
If yes, how often? _____
- ___ ___ Do you have blurred vision? Which eye? LT RT
- ___ ___ Do you have hearing loss? Which ear? LT RT
- ___ ___ Do you feel off balance or dizzy at times?
- ___ ___ Have you had any seizures? If yes, when?
- ___ ___ Any weakness in your arms? LT RT
- ___ ___ Any weakness in your legs? LT RT
- ___ ___ Have you had any previous strokes or bleeds in your
head? Please specify? _____
- ___ ___ Have you had any previous brain surgery?
- ___ ___ Do you have any family history of aneurysms or
AVM's?
- ___ ___ Have you had any form of cancer?
Please specify? _____
- ___ ___ Have you had any radiation or chemotherapy (Circle)

CONTRAST INJECTION WORKSHEET

YES NO

- ___ ___ Do you have any allergies?
List _____
- ___ ___ Have you ever had a reaction to Iodine(X-Ray dye)?
- ___ ___ Do you have asthma?
- ___ ___ Do you have diabetes?
- ___ ___ Do you take oral Glucophage/Metformin
- ___ ___ History of kidney disease or kidney surgery?
- ___ ___ Do you have a history of Myeloma?
- ___ ___ Do you have Sickle Cell Anemia?
- ___ ___ Do you have Thalassemia?

CARDIAC HISTORY

YES NO

- ___ ___ High Blood Pressure
- ___ ___ Heart Disease(Type) _____
- ___ ___ Acute MI/Previous Heart Attack
- ___ ___ Chronic Obstructive Pulmonary Disease/COPD
- ___ ___ Congestive Heart Failure/CHF
- ___ ___ Arrhythmia/Irregular Heart Beat(Type)

PATIENT SIGNATURE _____

TECHNOLOGIST _____ BUN _____ CREATININE _____

CONTRAST _____ AMOUNT _____ INJ SITE _____