MOLECULAR
imaging of suburban chicago

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 Thallasemia?

☐ 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 _____