

**CT OUTPATIENT QUESTIONNAIRE**

Please check the answers that apply to your **current or past** medical history (complete both sides of this form).

Have you ever been diagnosed with cancer?  Yes  No  Unknown

If yes, when/where: \_\_\_\_\_

Have you ever been diagnosed with T.B. or any other infectious disease?  Yes  No  Unknown

Have you ever taken medication on a regular basis to treat asthma?  Yes  No  Unknown

Are you highly sensitive to the environment, foods or drugs (hayfever, hives)?  Yes  No  Unknown

Have you been medically treated to reverse/prevent an Iodine (X-Ray dye) allergy?  Yes  No  Unknown

Do you have any kidney disease other than kidney stones?  Yes  No  Unknown

Have you ever been diagnosed with AIDS?  Yes  No  Unknown

Do you have any history of multiple myeloma?  Yes  No  Unknown

Have you had any blood work drawn within the last 3 months?  Yes  No  Unknown

If yes, where: \_\_\_\_\_

Do you have any other exams/tests scheduled today?  Yes  No  Unknown

If yes, please list: \_\_\_\_\_

**FEMALE ONLY:**

Are you pregnant, or could possibly be pregnant?  Yes  No  Unknown

Are you currently breast feeding?  Yes  No  Unknown

**DIABETICS ONLY:**

Are you taking any medications that contain Metformin?  Yes  No  Unknown

Diet controlled?  Yes  No  Unknown

Controlled with oral medication? If yes, list name: \_\_\_\_\_  Yes  No  Unknown

Controlled with insulin?  Yes  No  Unknown

MEDICATIONS	ALLERGIES	SURGICAL HISTORY
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None

Check all that apply, select the most appropriate time frame you have been experiencing those symptoms.

HEAD/BRAIN SCAN ONLY		BODY SCAN ONLY	
<input type="checkbox"/> Pain	How long? _____	<input type="checkbox"/> Pain	How long? _____
<input type="checkbox"/> Headache	How long? _____	<input type="checkbox"/> Hard to swallow	How long? _____
<input type="checkbox"/> Seizure	How long? _____	<input type="checkbox"/> Nausea	How long? _____
<input type="checkbox"/> Weakness	How long? _____	<input type="checkbox"/> Vomiting	How long? _____
<input type="checkbox"/> Visual problems	How long? _____	<input type="checkbox"/> Diarrhea	How long? _____
<input type="checkbox"/> Numbness	How long? _____	<input type="checkbox"/> Constipation	How long? _____
<input type="checkbox"/> Speech problems	How long? _____	<input type="checkbox"/> Weight Loss	How long? _____
<input type="checkbox"/> Difficulty walking	How long? _____	<input type="checkbox"/> Cough	How long? _____
<input type="checkbox"/> Difficulty thinking	How long? _____	<input type="checkbox"/> Yellowing skin	How long? _____

**CT QUESTIONNAIRE****Radiology Department**

PS 4256

Side 1 of 2

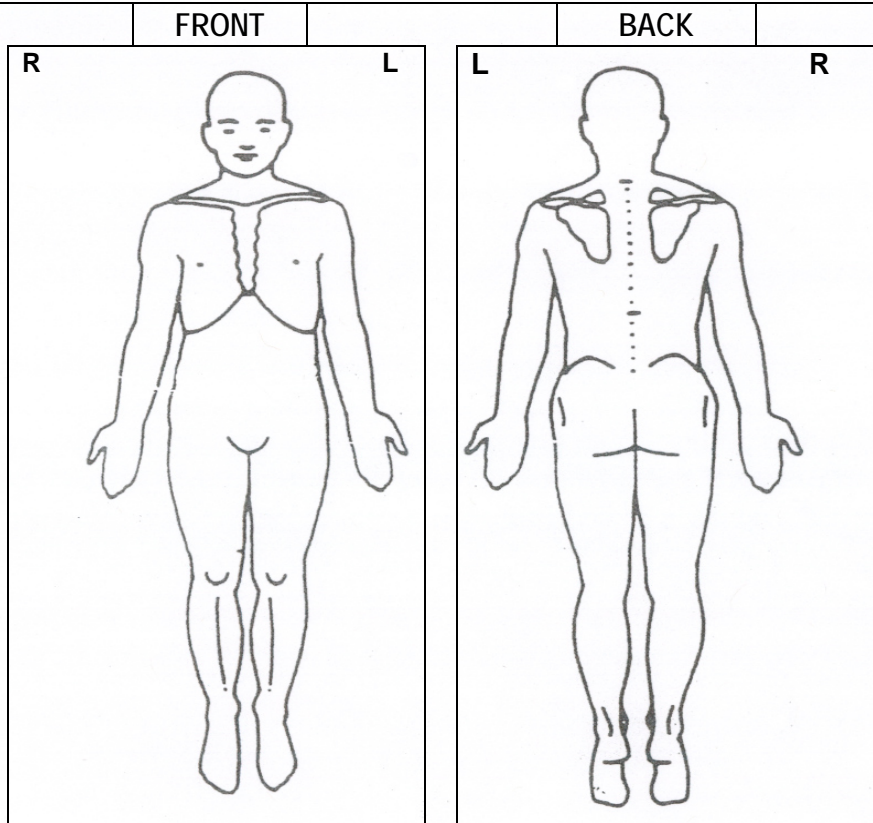
07/08/09



[2050]

Please further describe YES answers.  
Describe any other concerns you would like the Radiologist to know.

Please shade the area that hurts:



**NURSES ONLY**

Date: \_\_\_\_\_  
 Bun: \_\_\_\_\_  
 Creat: \_\_\_\_\_

Action Taken:

RN initials:

*Your signature denotes that all information given is true and correct.  
Do not sign until all your questions and concerns have been addressed and/or answered.*

\_\_\_\_\_  
 [Patient Signature]

\_\_\_\_\_  
 [Date]

\_\_\_\_\_  
 [Time] A.M./P.M.

\_\_\_\_\_  
 [If signed by other than patient, indicate relationship]

\_\_\_\_\_  
 [Reviewed By]

\_\_\_\_\_  
 [Date]

\_\_\_\_\_  
 [Time] A.M./P.M.