PREMIER IMAGING
Focused on Providing Superior and Expanded Imaging Care
Encompass Medical Group

CT QUESTIONNAIRE

YOUR MEDICAL HISTORY:

1. **LIST ANY PREVIOUS SURGERIES:**
   _____YES _____NO Cholecystectomy (gallbladder removed)
   _____YES _____NO Appendectomy (appendix removed)
   _____YES _____NO Hysterectomy
   _____YES _____NO Any other surgeries? Please List: _____

   _____

2. **HAVE YOU EVER BEEN DIAGNOSED WITH CANCER? _____YES _____NO**

   If yes, what kind?_____ When was the last diagnosis made?_____

   Have you ever had chemotherapy?_____Yes_____No Last treatment date:_____

   Have you ever had radiation therapy?_____Yes _____No Last treatment date:_____

3. **HAVE YOU HAD A PREVIOUS DIAGNOSTIC TEST RELATED TO THE PRESENT SYMPTOMS? (cat scan, MRI, or ultrasound)**

   _____YES _____NO When and Where:_____

CONSENT FOR IV CONTRAST INJECTION:

IODINATED INTRAVENOUS CONTRAST AGENTS, POSE A SMALL RISK OF REACTION, WHICH CAN RANGE IN SEVERITY FROM MINOR TO FATAL. COMPLICATIONS CAN BE SIGNIFICANTLY REDUCED WHEN WE PROPERLY ASSESS YOUR HEALTH STATUS, OBTAIN YOUR MEDICAL HISTORY, AND REVIEW PREVIOUS CONTRAST REACTIONS.

PATIENT RISK FACTORS:

1. HAVE YOU EVER HAD A PROCEDURE THAT REQUIRED THE INJECTION OF CONTRAST MATERIAL? (X RAY DYE)
   _____YES _____NO
2. HAVE YOU EVER HAD A REACTION TO IODINATED CONTRAST MATERIAL OR IODINE?
   _____ YES _____ NO
3. DO YOU HAVE A HISTORY OF AN ALLERGIC REACTION TO ANY SUBSTANCE? _____YES _____NO
4. DO YOU HAVE A HISTORY OF MULTIPLE MYELOMA? _____YES _____NO
5. DO YOU HAVE A HISTORY OF ASTHMA? _____YES _____NO
6. DO YOU HAVE A HISTORY OF HYPERTENSION OR HYPOTENSION? _____YES _____NO
7. DO YOU HAVE A HISTORY OF KIDNEY DISEASE OR DYSFUNCTION? _____YES _____NO
8. DO YOU HAVE DIABETES? _____YES _____NO

***GLUCOPHAGE AND METFORMIN** MUST BE HELD FOR **48 HOURS** FOLLOWING THE CT EXAM**

FEMALE PATIENTS:

1. WHEN WAS THE 1ST DAY OF YOUR LAST MENSTRUAL PERIOD? _____
2. COULD YOU BE OR ARE YOU PREGNANT, OR NURSING AN INFANT? _____
3. HAVE YOU HAD A HYSTERECTOMY? _____YES _____NO

I, _____, CONSENT TO THE CONTRAST INJECTED CT PROCEDURE; AND HAVE BEEN INFORMED OF AND UNDERSTAND THE RISKS INVOLVED.

_____ _____
(SIGNATURE) **(DATE)**

For Administrative Use Only

☐ Patient verification checked through name & DOB ☐ Labs verified

☐ Technologists performing verification _____ ☐ Patient shielded