

## BODY CT HISTORY QUESTIONNAIRE

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ ARE YOU PREGNANT? (Y/N) \_\_\_\_\_

1. WHY DID YOUR DOCTOR ORDER THIS EXAM? \_\_\_\_\_

\_\_\_\_\_

2. DO YOU HAVE: (Y/N – if Yes, explain)

A. Chest Pain \_\_\_\_\_

B. Abdomen Pain \_\_\_\_\_

C. Weight Loss/Fatigue \_\_\_\_\_

D. Change in Appetite \_\_\_\_\_

E. Diabetes \_\_\_\_\_ Are you on Glucophage? \_\_\_\_\_

F. Fever \_\_\_\_\_

G. Allergies \_\_\_\_\_

Allergic to:

Reaction:

▪ Contrast \_\_\_\_\_

▪ Medication \_\_\_\_\_

3. DO YOU HAVE OR HAVE YOU EVER HAD CANCER? \_\_\_\_\_ If yes:

A. What type? \_\_\_\_\_

B. Surgery (Type and When)? \_\_\_\_\_

C. Radiation Therapy (When)? \_\_\_\_\_

D. Chemotherapy (When)? \_\_\_\_\_

4. HAVE YOU EVER HAD PRIOR SURGERY? \_\_\_\_\_ If yes, what type and when? \_\_\_\_\_

\_\_\_\_\_

5. HAVE YOU HAD PRIOR RADIOLOGY EXAMS RELATED TO THE CURRENT PROBLEM (i.e., CT, MRI, Ultrasound, Nuclear Medicine)? \_\_\_\_\_

6. IF THERE IS ANY ADDITIONAL INFORMATION THAT YOU FEEL IS RELEVANT, PLEASE ADD:

\_\_\_\_\_

**For Technologist Use Only:**

Contrast Type and Amount \_\_\_\_\_

Contrast Reaction: No \_\_\_\_\_ Yes \_\_\_\_\_ What Type? \_\_\_\_\_

Technologist's Initials \_\_\_\_\_ If ISOVUE was used, why? \_\_\_\_\_