MRI & CT
Outpatient Imaging Center of Springfield

CT PATIENT QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____

ORDERING PHYSICIAN: _____ DATE: _____

TYPE OF EXAM:_____

GENERAL MEDICAL HISTORY

SYMPTOMS FOR TODAY'S EXAM: _____

Do you have a history of surgery ***in area being scanned***? If so, what and when? _____

HEIGHT:_____ WEIGHT:_____

Are you pregnant, could be pregnant or breast feeding? **YES** **NO**

Have you ever had prior contrast studies? **YES** **NO**

Have you ever had an allergic reaction to a contrasted study? **YES** **NO** **IF YES PLEASE DESCRIBE:_____**

_____

Do you have any of the following: **(please circle)**

Asthma, kidney problems, lupus, multiple myeloma, myasthenia gravis, heart problems, or diabetes?

Do you have any personal history of cancer? YES NO TYPE:_____

Do you take non-steroidal anti-inflammatory (aspirin like) drugs chronically or in high doses? **YES** **NO**

Do you have any heart problems? **YES** **NO**

Please list any medication you are on:_____

_____

PRINTED PATIENT NAME:_____ DATE: _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _____

SIGNATURE OF TECHNOLOGIST: _____