BAY COLONY

Date of Birth:
Referring Physician:

CT QUESTIONNAIRE

Why has your physician sent you for CT Scan? ______________________________

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Are you experiencing any of the following? (Please Check)

_____Pain _____Fever _____Nausea _____Vomiting _____Constipation _____Diarrhea

Have you have ever been diagnosed with the following? (Please Check)

___Diabetes If diabetic, do you take Glucophage, Metaformin, Glucovance? YES NO

___Hepatitis ____Cirrhosis of the Liver ____High Cholesterol ____Kidney Stones ____High Blood Pressure

Have you had any of the following Surgeries? (Please Check)

____Gallbladder ______Appendix _____Tubal Ligation _____Hysterectomy

Please list any other surgeries: ______________________________

Please list any known allergies: ______________________________
Do you have any significant health problems? If so, please list: ______________________________

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HIV _______ Hepatitis ______ TB ______ AIDS ______ Other: ______________

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Have you ever been a smoker? ___________ How long? ______________
How often do you drink alcohol? ______________ times per week / month.

What is your approximate Height _____________, and approximate Weight ___________ lbs.
Have you had any of the following diagnostic studies?

Ultrasound: yes no What part of Body? ______________________________

Cat Scan: yes no What part of Body? ______________________________

MRI: yes no What part of Body? ______________________________

Have you ever been injected with iodine contrast? ***YES*** ***NO***

Can you eat shellfish and shrimp? ***YES*** ***NO***

FEMALES:
When was the first day of your last menstral period? ______________
Is there any chance you could be pregnant? yes no
Are you currently on Birth Control? yes no

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Patient Signature ______________________________
Date ______________________________

Witness ______________________________
Date ______________________________