Saint Clare's Health

DIAGNOSTIC IMAGING/CT PATIENT QUESTIONNAIRE

☐ Inpatient ☐ Outpatient

PLEASE PRINT

PATIENT'S NAME: _____ **DOB:** _____ **DATE:** _____

- What is the Diagnosis/Reason for Exam/Symptoms?

  _____

- Have you ever had a CT Scan, PET Scan or PET/CT Scan? ☐Yes ☐No
  If yes, indicate the date and facility of the scan: _____

- What is your height? _____ What is your weight? _____

- Have you ever had an injection of IV contrast? (CT scan Dye)? ☐Yes ☐No
  If yes, have you ever had a reaction? ☐Yes ☐No
  If yes, please describe reaction(s):

  _____

- Do you have any allergies to food, medication or latex? ☐Yes ☐No
  If yes, please specify:

  _____

- If you are a female of child bearing age, is there a chance you might be pregnant? ☐Yes ☐No

- Are you diabetic? ☐Yes ☐No
  If yes, are you taking any of the following: ☐Glucophage ☐Glucovance ☐Metformin Other: _____

- Do you have a history of kidney disease? ☐Yes ☐No
  If yes, please specify:

  _____

- Have you ever had surgery(s)? ☐Yes ☐No
  If yes, please specify type/date:

  _____

- Do you have a history of cancer? ☐Yes ☐No
  If yes, type(s): _____
  Approximately, when were you diagnosed (month/year)? _____
  Have you ever had Chemotherapy? ☐Yes ☐No
  If yes, what is the approximate date of your last therapy: _____
  Have you ever had Radiation therapy? ☐Yes ☐No
  If yes, what is the approximate date of your last therapy? _____

PATIENT'S SIGNATURE: _____