LAKESIDE MRI & DIAGNOSTIC HEALTH

CT QUESTIONNAIRE

NAME: _____, _____
(Last) (First)

HEIGHT:_____ WEIGHT:_____lbs

MEDICAL HISTORY

ARE YOU EXPERIENCING PAIN OR OTHER SYMPTOMS? ☐ YES ☐ NO If yes, please list:

_____

ARE YOU BEING TREATED FOR ANY OTHER MEDICAL PROBLEM? ☐ YES ☐ NO If yes, please list:

_____

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER? ☐ YES ☐ NO If yes, please describe:

_____

HAVE YOU EXPERIENCED TRAUMA OR INJURY RECENTLY? ☐ YES ☐ NO If yes, please describe:

_____

HAVE YOU HAD ANY SURGERY? ☐ YES ☐ NO If yes, please list:

_____ DATE: _____

_____ DATE: _____

_____ DATE: _____

ARE YOU ALLERGIC TO:

MEDICATIONS? ☐ YES ☐ NO If yes, please list: _____

IODINE? ☐ YES ☐ NO If yes, please list: _____

SHELLFISH? ☐ YES ☐ NO If yes, please list: _____

OTHER? ☐ YES ☐ NO If yes, please list: _____

ARE YOU DIABETIC? ☐ YES ☐ NO If yes, what medication(s) are you currently taking for this condition?

DO YOU HAVE HYPERTENSION? ☐ YES ☐ NO

DO YOU HAVE HISTORY OF RENAL FAILURE OR KIDNEY DISEASE? DIALYSIS? ☐ YES ☐ NO

HAVE YOU EVER HAD A PREVIOUS REACTION TO ANY CONTRAST MEDIA? ☐ YES ☐ NO

HAVE YOU HAD ANY OTHER DIAGNOSTIC TESTS FOR THIS CONDITION? ☐ YES ☐ NO

WHERE?_____WHEN?_____WHAT KIND?_____

FEMALE PATIENTS ONLY

ANY CHANCE OF PREGNANCY? ☐ YES ☐ NO

ARE YOU CURRENTLY BREASTFEEDING? ☐ YES ☐ NO

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

_____ _____
Signature Date

TECH INITIALS: _____