



CT PROCEDURE SCREENING FORM FOR PATIENTS

Date: \_\_\_/\_\_\_/\_\_\_ Patient Number: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Gender:  M  F Primary Care Phys: \_\_\_\_\_

Type of study to be performed: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Symptoms: \_\_\_\_\_

1. Have you had prior surgery or an operation (e.g. arthroscopy, endoscopy, etc.) of any kind?  Yes  No

If yes, please indicate the date and type of surgery:

Date \_\_\_/\_\_\_/\_\_\_ Type of Surgery \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_ Type of Surgery \_\_\_\_\_

2. Have you had a prior CT study or examination relevant to the study you are having today?  Yes  No

Table with 4 columns: Test, Date, Facility. Includes two rows of blank lines for data entry.

3. Have you ever been injected with X-ray/CT dye?  Yes  No

If you had a reaction to the dye, please describe it: \_\_\_\_\_

3. Do you have a personal history of cancer?  Yes  No

If yes, what type? \_\_\_\_\_

4. Are you currently taking any medication?  Yes  No

If yes, please list: \_\_\_\_\_

5. Are you allergic to any medication?  Yes  No

If yes, please list: \_\_\_\_\_

6. Are you pregnant, breastfeeding or suspect that you are pregnant?  Yes  No

LMP \_\_\_\_\_

Please indicate if you have any of the following:

- List of medical conditions with Yes/No checkboxes: Asthma, Diabetes, Hay Fever, Heart Problems, High Blood Pressure, History of Stroke, Kidney Problems, Sickle Cell Anemia, Dentures or Partial Plates.

I attest the above information is correct to the best of my knowledge.

Signature of person completing form: \_\_\_\_\_ Date \_\_\_\_\_

Form information reviewed by: \_\_\_\_\_  Technologist  Physician