Reston Radiology Consultants

BODY CT HISTORY QUESTIONNAIRE

NAME: _____ DOB: _____ DATE: _____

REFERRING PHYSICIAN: _____ ARE YOU PREGNANT? (Y/N) _____ LMP_____

1. **WHY DID YOUR DOCTOR ORDER THIS EXAM?** _____
_____

2. **DO YOU HAVE:** (Y/N – if Yes, explain)

A. Chest Pain _____ _____
B. Abdomen Pain _____ _____
C. Weight Loss/Fatigue _____ _____
D. Change in Appetite _____ _____
E. Diabetes _____ **Are you on Glucophage?** _____
F. Fever _____ _____
G. Do you smoke? _____ Year stopped _____
H. Kidney Disease _____ _____
I. Asthma _____ _____

Allergic to: **Reaction:**

- Contrast _____ _____
- Medication _____ _____

3. **DO YOU HAVE OR HAVE YOU EVER HAD CANCER?** _____
   A. What type? _____
   B. Surgery (Type and When)? _____
   C. Radiation Therapy (When)? _____
   D. Chemotherapy (When)? _____

4. **HAVE YOU EVER HAD PRIOR SURGERY?** _____ **If yes, what type and when?** _____
_____

5. **HAVE YOU HAD PRIOR RADIOLOGY EXAMS RELATED TO THE CURRENT PROBLEM** (i.e., CT, MRI, Ultrasound, Nuclear Medicine)? _____

6. **IF THERE IS ANY ADDITIONAL INFORMATION THAT YOU FEEL IS RELEVANT, PLEASE ADD:**
_____

For technologist use only:

Contrast Type and Amount_____IV_____

Contrast Reaction: No _____ Yes _____ What type/Treatment _____

Technologist's Initials _____