NORTH DOVER RADIOLOGY

CT QUESTIONNAIRE

*APPT BY:*_____

APPOINTMENT DATE_____**TIME**_____

Do You Have A Follow-up Appt. with your Doctor? _____ ***When?***_____

Patient's Name _____ **DOB**_____ (**Circle)** Male/Female

Type of Scan_____R/O_____

Referring Physician _____ **Phone #**_____

Weight _____ **Age** _____ ***(*****Any patient with diabetes, kidney failures or over 60 must have blood work)**

Any history of smoking	☐ **YES** ☐ **NO** ☐ **N/A**	
Are you allergic to iodine or contrast dye	☐ **YES** ☐ **NO** ☐ **N/A**	**If so, what happens** _____
Are you allergic to shellfish	☐ **YES** ☐ **NO** ☐ **N/A**	**If so, what happens** _____
Do you have any allergies	☐ **YES** ☐ **NO** ☐ **N/A**	
Do you have any history of asthma or difficulty breathing	☐ **YES** ☐ **NO** ☐ **N/A**	
Are you diabetic/Blood work needed	☐ **YES** ☐ **NO** ☐ **N/A**	**If yes, what medication do you take** _____
Are you on Dialysis	☐ **YES** ☐ **NO** ☐ **N/A**	**IF SO PATIENT MUST SCHEDULE DIALYSIS AFTER SCAN**
Do you have any kidney/renal disease	☐ **YES** ☐ **NO** ☐ **N/A**	
Do you have any history of cancer	☐ **YES** ☐ **NO** ☐ **N/A**	**If so, what happens** _____
Is there a possibility you might be pregnant	☐ **YES** ☐ **NO** ☐ **N/A**	**LAST LMP** _____
Are you able to walk without assistance	☐ **YES** ☐ **NO** ☐ **N/A**	
Patient over 60 MUST they have blood work	☐ **YES** ☐ **NO** ☐ **N/A**	**FRONT DESK MUST OBTAIN BLOODWORK (LABS: BUN, GFR, CREATINE)**
Have you had any previous exams of the same body part	☐ **YES** ☐ **NO** ☐ **N/A**	

NOTES/SPECIAL INSTRUCTIONS:

Attachments: ☐ Prior Exam ☐ Blood work ☐ Script

Patient/Guardian Signature: _____ **Date:** _____

PATIENT: Please review the information provided at the time of scheduling. Your Signature will verify its accuracy

Front Desk Only: Date: _____ ☐ **CONFIRMED** ☐ **LEFT MESSAGE** ☐ **NO ANSWER**

For Contrast studies: ☐ **instructed patient to drink water**