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 _____