Reston Radiology Consultants

HEAD CT HISTORY QUESTIONNAIRE

NAME: _____ DOB: _____ DATE: _____

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

1. WHY DID YOUR DOCTOR ORDER THIS EXAM? _____

   _____

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

   A. Headaches _____ _____

   B. Blurred or Double Vision _____ _____

   C. Dizziness _____ _____

   D. Trauma to your head _____ _____

   E. Sinusitis _____ _____

   F. Diabetes _____ Are you on Glucophage? _____

   G. Asthma _____ _____

   H. Allergies _____ _____

Allergic to:		Reaction:
▪ Contrast	_____	_____
▪ Medication	_____	_____

3. DO YOU HAVE OR HAVE YOU EVER HAD CANCER? _____ If yes:

   A. What type? _____

   B. Surgery (Type and When)? _____

   C. Radiation Therapy (When)? _____

   D. Chemotherapy (When)? _____

4. HAVE YOU EVER HAD PRIOR HEAD 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 _____ If ISOVUE was used, why? _____