Freehold Radiology Group
Freehold MR Associates, PA

CT SCREENING QUESTIONNAIRE

NAME _____ SEX _____ AGE _____

REFERRING PHYSICIAN _____ DOB _____ WEIGHT _____ HEIGHT_____

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

DO YOU HAVE ALLERGIES? YES NO
IF YES, PLEASE LIST _____

DO YOU HAVE ASTHMA? YES NO

ARE YOU A DIABETIC? YES NO

IF YES, DO YOU TAKE GLUCOPHAGE, GLUCOVANCE, METFORMIN, METAGLIP, JANUMET, AVANDAMET, ACTOPLUS, FORTAMET, RIOMET, GLUMETZA, PRANDIMET? (Circle medication taking for diabetes)

DO YOU HAVE SEVERE OR INCAPACITATING HEART DISEASE? YES NO

DO YOU HAVE SICKLE CELL DISEASE? YES NO

DO YOU HAVE MULTIPLE MYELOMA? YES NO

DO YOU HAVE KIDNEY FAILURE? YES NO

DO YOU HAVE A HISTORY OF CANCER? YES NO
IF YES, WHAT TYPE? _____

HAVE YOU HAD RADIATION OR CHEMOTHERAPY? YES NO

HAVE YOU EVER HAD AN ADVERSE REACTION TO CONTRAST? YES NO
(Sensation of heat, flushed feeling, nausea/vomiting does not qualify as an adverse reaction)

HAVE YOU HAD SURGERY TO THE AREA BEING SCANNED? YES NO
IF YES, WHAT TYPE? _____

FEMALE PATIENTS, PLEASE ANSWER ADDITIONAL INFORMATION:

WHAT IS THE FIRST DAY OF YOUR LAST MENSTRUAL PERIOD? _____

IS THERE ANY POSSIBILITY OF PREGNANCY? YES NO

ARE YOU CURRENTLY BREASTFEEDING? YES NO

ARE YOU POST MENOPAUSAL? YES NO

PAIN ASSESSMENT: Check the level of pain that applies

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I HAVE READ AND UNDERSTAND THE ENTIRE CONTENTS OF THIS FORM AND I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS REGARDING THE INFORMATION ON THIS FORM.

SIGNATURE: _____ DATE: _____
(Parent/guardian signature if patient is a minor)