Coastal Carolina Health Care, P.A.

Advanced Medicine. Trusted Care.

CT QUESTIONNAIRE

NAME: ______________________________ WEIGHT__________

REASON FOR EXAM: ______________________________

LOCATION OF PAIN: ______________________________

DO YOU HAVE HEART PROBLEMS? IF YES EXPLAIN: ______________________________

DO YOU TAKE METFORMIN OR COMBINATION? ______________________________

HISTORY OF CANCER: Y_______ N_________ What kind? ______________________________

IF YES, WHAT KIND OF TREATMENT? ______________________________

ANY ALLERGIES? (yellow dye, x-ray dye, iodine, latex) Y N

Explain reaction______________________________

DID YOU TAKE A STEROID PREP TODAY? Y N

DO YOU HAVE KIDNEY PROBLEM? Y N

HAVE YOU EATEN IN THE LAST 4 HOURS: Y N

ARE YOU PREGNANT OR BREASTFEEDING? Y N

DO YOU HAVE : SICKLE CELL ANEMIA Y N

MULTIPLE MYELOMA Y N

HAVE ANY OF THE FOLLLOWING BEEN REMOVED? Circle yes or No for each

Appendix	Y	N	Part of Colon	Y	N	Uterus	Y	N
Gallbladder	Y	N	GI Tract	Y	N			

LIST ANY SURGERIES YOU HAVE HAD? ______________________________

HAVE YOU EVER HAD A CT BEFORE? Y N

WHERE AND WHEN? ______________________________

WHAT BODY PART? ______________________________

OFFICE USE ONLY

LABS:
BUN/CREAT_________ GFR________ DATE___________ ANGIO/PORT______ #____ ATTEMPTS

NOTES: ______________________________

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