

**CT OUTPATIENT QUESTIONNAIRE****CLINICAL HISTORY:**

Briefly describe the symptoms you are having that prompted your physician to order this scan:

How long have you had these symptoms: # Days: \_\_\_\_\_ # Weeks: \_\_\_\_\_ # Months: \_\_\_\_\_ # Years: \_\_\_\_\_

Has the area that we are scanning today been subjected to injury?  Yes  No If yes, how long ago: \_\_\_\_\_

Have you ever had surgery on the area that is being scanned?  Yes  No

If yes, please describe when and what type of surgery? \_\_\_\_\_

Have you ever been diagnosed (past or present) with any of the following (please check):

Cancer of \_\_\_\_\_ If yes, what was the date that you were diagnosed? \_\_\_\_\_

Tuberculosis  AIDS  Hepatitis  Multiple Myeloma  Other: \_\_\_\_\_

**CONTRAST STUDIES ONLY:****ALLERGIES:**

Do you have any allergies to contrast (x-ray dye)?  Yes  No  Unknown

If yes, what happened the last time you had contrast? \_\_\_\_\_

Do you have any allergies to latex?  Yes  No

List all other allergies \_\_\_\_\_

**KIDNEY DISEASE:**

Do you have any kidney disease other than kidney stone?  Yes  No

Are you diabetic?  Yes  No If yes, are you receiving dialysis?  Yes  No

Have you had any blood work drawn within the last 6 weeks?  Yes  No

If yes, where was it done? \_\_\_\_\_

**MEDICATION LIST OF CONTRAINDICATIONS:**

Are you taking any of these medications that contain Metformin? If yes, check next to the medication name.

Generic Name	Brand Name(s)	Check if YES
Metformin	Fortamet; Glucophage; Glucophage XR; Glumetza; Riomet	
Metformin and Aloglipton	Kazano	
Canagliflozin and Metformin	Invokamet	
Dapagliflozin and Metformin	Xigduo XR	
Empagliflozin and Metformin	Synjardy	
Glipizide and Metformin	Metaglip	
Glyburide and Metformin	Glucovance	
Linagliptin and Metformin	Jentadueto	
Pioglitazone and Metformin	Actoplus Met; Actoplus Met XR	
Repaglinide and Metformin	Prandimet	
Rosiglitazone and Metformin	Avandamet	
Saxagliptin and Metformin	Kombiglyze XR	
Sitagliptin and Metformin	Janumet; Janumet XR	

**PATIENT HEALTH HISTORY****Radiology Department**

PS 4256

Side 1 of 2

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**SYMPTOMS:**

Complete only those questions below which relate to the type of CT scan you are having:

HEAD / BRAIN:			CHEST:	NECK (Soft Tissue):
<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Trouble thinking	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Pain
<input type="checkbox"/> Numbness	<input type="checkbox"/> Weakness	<input type="checkbox"/> Trouble talking	<input type="checkbox"/> Tightness in chest	<input type="checkbox"/> Mass/Lump present
<input type="checkbox"/> Seizure	<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Trouble walking	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Difficulty swallowing
	<input type="checkbox"/> Visual problems		<input type="checkbox"/> Cough	<input type="checkbox"/> Difficulty talking
			<input type="checkbox"/> Pain	
ABDOMEN and/or PELVIS:	SPINE		BONE / ARM / LEG:	
<input type="checkbox"/> Pain	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Pain – circle (Up/Mid/Low) (R/L)	<input type="checkbox"/> Pain	
<input type="checkbox"/> Nausea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Weakness – circle (Up/Mid/Low) (R/L)	<input type="checkbox"/> Trauma	
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Yellowing skin	<input type="checkbox"/> Numbness – circle (Up/Mid/Low) (R/L)	<input type="checkbox"/> Mass/Lump present	
<input type="checkbox"/> Diarrhea			<input type="checkbox"/> Numbness	

Your signature denotes that all information given is true and correct. NOTE: Do not sign until all your questions/concerns have been answered.

Patient/Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by other than patient, indicate relationship: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_