HOAG MEMORIAL HOSPITAL PRESBYTERIAN

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 ever had any blood work drawn within the last 3 months? ☐ 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	

SYMPTOMS:

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

HEAD / BRAIN:			CHEST:	NECK (Soft Tissue):
☐ Headache	☐ Dizziness	☐ Trouble thinking	☐ Difficulty breathing	☐ Pain
☐ Numbness	☐ Weakness	☐ Trouble talking	☐ Tightness in chest	☐ Mass/Lump present
☐ Seizure	☐ Hearing problems	☐ Trouble walking	☐ Difficulty swallowing	☐ Difficulty swallowing
	☐ Visual problems		☐ Cough	☐ Difficulty talking
			☐ Pain	

ABDOMEN and/or PELVIS:		SPINE	BONE / ARM / LEG:
☐ Pain	☐ Weight loss	☐ Pain – circle (Up/Mid/Low) (R/L)	☐ Pain
☐ Nausea	☐ Constipation	☐ Weakness – circle (Up/Mid/Low) (R/L)	☐ Trauma
☐ Vomiting	☐ Yellowing skin	☐ Numbness – circle (Up/Mid/Low) (R/L)	☐ Mass/Lump present
☐ Diarrhea			☐ 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: _____