

MOUNTAINVIEW MEDICAL IMAGING CT QUESTIONNAIRE

Name _____ DOB _____ Date _____

What type of problem(s) are you currently having?

List any allergies (ie: pollen/dust, iodine, other) include allergies to medications.

Please list any medications you are currently taking. (including glucophage or glucovance)

Have you ever been injected with X-ray contrast, (x-ray dye)? Yes No
(For example CT scan, kidney x-ray, or heart catheterization.)

Have you had any reaction to any contrast dye? Yes No

Have you had a previous CT exam? Yes No
If yes give date and location _____

Do you currently or have you ever had asthma or respiratory failure? Yes No

Do you currently have or have you had any of the following Conditions?

Congestive Heart Failure	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No	Kidney Failure	Yes	No
Heart Attack	Yes	No	Multiple myeloma	Yes	No
Heart Disease	Yes	No	Angina	Yes	No
Severe arrhythmia	Yes	No	Sickle Cell Disease	Yes	No
Syncope	Yes	No	Other _____		

Have you ever had cancer? Yes No Yes, what type and when was it discovered?

Have you had radiation or chemotherapy? Yes No Yes, what was the date of your last treatment?

Please list any major medical problems or previous surgeries:

FEMALES: Ages 13 to 50:

Date of last menstrual period: _____

Is there a chance you could be pregnant? Yes No

Patient Signature _____

Date: _____

Technologist signature: _____

Date: _____