

**AMERICAN WELLNESS & IMAGING**  
**CT PATIENT QUESTIONNAIRE**

Appt. Date \_\_\_\_\_ Time \_\_\_\_\_

Name \_\_\_\_\_ Phone 1 \_\_\_\_\_ Phone  
2 \_\_\_\_\_

DOB \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ (if over 350 lbs., we cannot do a CT here)

Primary Care Physician \_\_\_\_\_ Ordering  
Physician \_\_\_\_\_

Date of Follow-Up Appt. w/  
Physician \_\_\_\_\_

Insurance \_\_\_\_\_ Precert  
\_\_\_\_\_

Scan / Study \_\_\_\_\_  
R/O \_\_\_\_\_

Appointment made by: \_\_\_\_\_ PT. \_\_\_\_\_ MD \_\_\_\_\_ INS CO. Scheduler \_\_\_\_\_  
Date \_\_\_\_\_

**BUN \_\_\_\_\_ Creatinine \_\_\_\_\_**

**This questionnaire is designed to assist us in determining if it is safe for you to undergo a CT Scan. It is important that you answer all of the following questions to the best of your knowledge.**

\_\_\_\_\_ Do you have a history of asthma, difficulty breathing or use of an inhaler? (if "yes", ask patient to please bring their inhaler)

\_\_\_\_\_ **\*Are you diabetic?** If so, what medications do you take? \_\_\_\_\_

(if taking Glucophage, Metformin, or Glucovance and if the CT is with IV contrast, you must STOP taking these medications the day of the exam and two days after AND talk to your Primary Care Physician or Endocrinologist about alternative treatment while not taking your regular medications).

\_\_\_\_\_ **\*Do you have a history of kidney disease?**

\_\_\_\_\_ Are you allergic to shellfish? If so, what is your reaction? \_\_\_\_\_

\_\_\_\_\_ Are you allergic to iodine or IV contrast injection (x-ray dye)? If so, what is your reaction? \_\_\_\_\_

(if "yes" to above allergies, patient should contact their Primary Care Physician regarding pretreatment with an antihistamine)

\_\_\_\_\_ Have you ever had surgery on the body part we are scanning? If yes, when? \_\_\_\_\_

\_\_\_\_\_ Do you have any previous related films? If yes, **PLEASE** bring your films and reports.

\_\_\_\_\_ **For Women:** Are you pregnant or nursing?

**\* For IV Contrast: ALL diabetic patients, ALL patients with kidney disease and ALL patients over age 60 must have BUN and CREATININE levels done within one month prior to their CT IV Contrast Exam. Please provide us with a copy of your lab report.**

**PATIENT HISTORY:**

\_\_\_\_\_ Do you have a history of cancer, leukemia or lymphoma?

\_\_\_\_\_ Have you ever had chemotherapy or radiation therapy?

\_\_\_\_\_ Do you have a history of heart disease, congestive heart failure, or irregular heart beat? \_\_\_\_\_

