

**HIC HENRY COUNTY
MIC MEDICAL CENTER**

Imaging 731-644-8480 Scheduling 731-644-8486
www.hcmc-tn.org

CT PATIENT QUESTIONNAIRE

NAME: _____ AGE: _____ SEX: M / F

PHYSICIAN: _____ DATE OF STUDY: _____

1. Are you pregnant? YES NO
IF YES OR NOT SURE, PLEASE TELL A TECHNOLOGIST NOW!
2. Have you had an X-Ray exam in which you received a contrast dye injection (i.e. CT Scan, IVP kidney exam) YES NO
3. Have you had a past reaction to X-Ray contrast or dye requiring treatment by a Doctor (other than nausea or hot flushed sensation)
IF YES, please describe _____ YES NO
4. Do you have allergies?
IF YES, please describe _____ YES NO
5. Do you have any of the following conditions: (PLEASE CHECK)
Diabetes (insulin dependent) Yes _____ No _____ Asthma Yes _____ No _____
Kidney Disease Yes _____ No _____ Respiratory problems Yes _____ No _____
Heart Disease/angina Yes _____ No _____ Liver Disease Yes _____ No _____
Intestinal problems Yes _____ No _____ Bladder Disease Yes _____ No _____
Prostate problems Yes _____ No _____ Head/Back problems Yes _____ No _____
Cancer Yes _____ No _____
If Yes, briefly describe _____
6. List any heart, lung or kidney medications you are taking _____

7. Are you taking Glucophage, Metformin, Metaglip or Other _____
8. Why are you having this CT scan? _____
9. Have you had any imaging studies involving this same area? Yes _____ No _____
Type of study _____ Where _____ When _____

I acknowledge that all the information given is accurate and thereby consent to have Cat scan procedure (w/contrast if necessary) performed on me.

The technologist will explain in detail what will be involved in order to perform this examination. You are encouraged to ask any questions that you may have regarding this procedure.

_____ Date: ____/____/____
Patient's Signature

Technologist to Complete Below this Line

Tech: _____ Contrast used: _____ / _____ cc's Lot # _____ Volume: _____
BUN: _____ Creatinine _____ Date of Lab results _____