



UNIVERSITY RADIOLOGY

WELCOME TO A DIFFERENT WAY OF DOING THINGS IN RADIOLOGY

CT Questionnaire

Patient's Name: _____ Date: _____

Birthdate: _____ Age: _____ Weight: _____

Ordering Physician: _____

Reason for test / your symptoms: _____

Previous CT Exams:

Have you had a CT at UT Medical Center? Yes No When? _____

Have you had a CT anywhere else? Yes No

Where/When: _____

Have you had IV Contrast (X-Ray Dye) before? Yes No

If yes, did you experience any problems with the dye / contrast? _____

Describe the problem? _____

If Female, is there any possibility that you are pregnant? Yes No

Are you currently breast feeding? Yes No

Medical History

Diabetes: Yes No If yes, are you taking Metformin*? Yes No
*(Glucophage, Avandament, Metaglip, Glucovance, Fortament, Riomet)

Medication Allergies: _____

Please Circle All That Apply

High Blood Pressure	Multiple Myeloma	Cancer
Heart Disease	Liver Disease	Kidney Disease

Surgical History: _____

Current Medications: _____

Patient Signature: _____

OFFICE USE ONLY

Creatinine: _____ Isovue 370 _____ cc Technologist Initials: _____

Contrast Reactions: _____

Contrast Extravasation: _____