OPEN IMAGING
OF LONGVIEW

1010 N. 6th Street • Longview, Texas 75601 • (903) 757-9596 • (866) 757-9596

CT PATIENT QUESTIONNAIRE

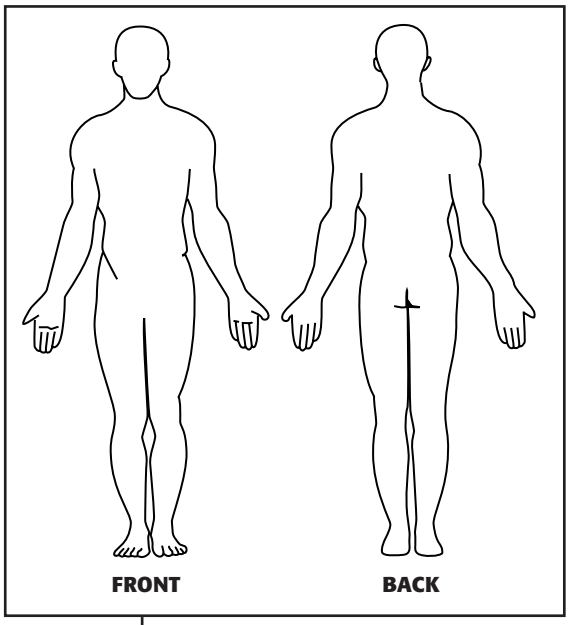
Name: _____ **Age:** _____ **Sex:** _____ **Weight:** _____

Describe Symptoms: _____

_____

HEAD STUDIES:
Check all that apply
_____ Head injury
_____ Headaches
_____ Dizziness
_____ Blackouts
_____ Seizures
_____ Previous stroke

SPINE STUDIES:
Check all that apply
_____ Arm injury
_____ Arm pain
_____ Arm numbness
_____ Leg injury
_____ Leg pain
_____ Leg numbness



Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.).

CHEST AND ABDOMEN STUDIES:
Check all that apply

_____ Pain	_____ Blood in stool	_____ Vomiting blood
_____ Blood in urine	_____ Smoker	_____ Congestive heart failure
_____ Cough	_____ Nausea or vomiting	_____ Possibility of pregnancy

Last menstrual period: _____

SURGICAL HISTORY:
List all surgeries: _____

List previous exams: _____

PATIENT HISTORY: *Select the appropriate answers*

Allergies requiring medication	Yes	No	Severe arrhythmia/Irregular heartbeat	Yes	No
If yes, is this prescription?	Yes	No	Heart block (2nd or 3rd degree)	Yes	No
Food allergies	Yes	No	Recent myocardial infarction/heart attack	Yes	No
Drug allergies	Yes	No	Generalized severe debilitation	Yes	No
Hives	Yes	No	Have you ever had cancer?	Yes	No
Hay fever	Yes	No	If yes, list type _____		
Asthma	Yes	No	Sickel-cell anemia	Yes	No
Seizures	Yes	No	Low blood count (anemia)	Yes	No
Unstable angina/Severe chest pain caused by lack of oxygen to the heart				Yes	No
Pulmonary hypertension/High blood pressure in the arteries that supply the lungs				Yes	No

Have you ever been given, or are you currently receiving, radiation or chemotherapy treatments? Yes No
Date of last treatment: _____

Do you have a history of kidney problems? Yes No
If yes, please describe: _____

Do you have a history of adverse reaction to contrast material, with the exception of a sensation of heat, flushing or a single episode of nausea or vomiting? Yes No

Do you have a history of diabetes? Yes No
If yes, are you taking a medication called Glucophage, Metformin Hydrochloride, Glucovance, Avandamet or Fortamet? Yes No
IF YES, PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY

Is this procedure being done due to a work-related injury? Yes No
Please describe: _____

Is this procedure being done due to an automobile accident? Yes No
Please describe: _____

Signature: _____ Date: _____

I attest that the above information is correct to the best of my knowledge.

TO BE COMPLETED BY DEPARTMENTAL STAFF

Exam: _____ Reason for exam: _____ Creatinine: _____
Contrast type: _____ Amount/RateSite: _____
Technologist: _____ Date: _____