

LP AND CT SCAN QUESTIONNAIRE

NAME: _____ D.O.B. _____

WHERE IS THE BEST PLACE TO REACH YOU DURING THE DAY?

HOME _____ CELL _____ WORK _____

MAY WE LEAVE A MESSAGE ON VOICE MAIL? Yes No

MAY WE LEAVE INFORMATION WITH ANOTHER INDIVIDUAL?

WHO? _____

THESE QUESTIONS WILL HELP US TO SCHEDULE YOUR PROCEDURE:

Do you have allergies to IODINE, CONTRAST DYE, or SHELLFISH? Yes No

Are you diabetic? Yes No

If yes, are you taking GLUCOPHAGE? Yes No

Do you have any RENAL/KIDNEY or LIVER DISEASE? Yes No

Do you take any BLOOD THINNERS? Yes No

Have you had any testing with contrast or barium in the last 2 days? Yes No

Have you ever had any surgery to the area being scanned or tested? Yes No

If yes, where and what year? _____

WEIGHT: _____ HEIGHT: _____

SCHEDULING: Please circle the days that are best for you.

MON. TUES. WED. THURS. FRI. SAT.

Do you prefer: MORNING, AFTERNOON, EVENING, ANYTIME?

FEMALES ONLY – ARE YOU PREGNANT? Yes No