CT SCREENING FORM

Today's Date: ______________________

Name: ___________________________________ Sex: **M** *or* **F** Weight: _____________ Height: ______________

Date of Birth: _____________________________

Why did your doctor order this scan? ____

Please describe any pain or discomfort you have currently: ____

Have you ever had a CT scan before? If yes, what type, when, and where? _______________________________

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Do you have, or have you ever had any of the following?	**YES**	**NO**
Allergies to food or medications?		
A current or previous diagnosis of cancer?		
If yes, what type and when?		
What kind of treatment did you receive and when?		
Have you ever had a major surgery?		
If yes, what kind and when?		
Do you have any major medical conditions?		
If yes, what?		
Are you pregnant or is there a chance that you may be pregnant?		
Are you currently breastfeeding?		

I attest that the information provided is correct to the best of my knowledge. I have read and understand the contents of this form and I have had the opportunity to ask questions regarding the information on this form. I understand if I provided any false information, I am held responsible for any injury or risk that may be involved with having this study.

X ____ Date: ________________________

Patient/Parent/Legal Guardian

X ____ Date: ________________________

CT Technologist Signature