



**CT Spine Questionnaire**

Name: \_\_\_\_\_ D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: M/F WT: \_\_\_\_\_ lbs

Why are you having the exam? (Symptom): \_\_\_\_\_

What side, location, body part are involved? (Location): \_\_\_\_\_

How long have you had this problem? (Duration): \_\_\_\_\_

If due to injury, how did it occur? (Mechanism of Injury): \_\_\_\_\_

YES NO Is there any chance you may be pregnant? Date of last menstrual period? \_\_\_\_\_

YES NO Do you wear a Dexcom, Libre, or other glucose monitor? \_

YES NO Have you had a spinal injection? What type? \_\_\_\_\_

YES NO Any prior imaging of the area? Where/when? \_\_\_\_\_

YES NO Any prior surgery of the area? Type/dates? \_\_\_\_\_

YES NO Do you have unexplained fever?

YES NO Are you immunocompromised? If uncertain, select NO.

YES NO Do you have a history of being diagnosed with cancer? Type? \_\_\_\_\_

YES NO Any radiation therapy? If YES, dates? \_\_\_\_\_

YES NO Any chemotherapy? If YES, dates/type? \_\_\_\_\_

YES NO Are you in a lung cancer screening program with yearly CTs of the chest?

YES NO Do you now or have you ever smoked?

If YES, how many years did you smoke? \_\_\_\_\_ years

How many packs per day did you smoke? \_\_\_\_\_ packs per day

How long ago did you quit? If still smoking, mark as "0": \_\_\_\_\_ years ago

**I acknowledge that all the information given is accurate and thereby consent to have CT with or without an injection of contrast performed on me.**

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Technologist Notes: \_\_\_\_\_

Technologist Initials: \_\_\_\_\_