CT Extremity Questionnaire

Name:_________________________________ D.O.B.___/___/___ Sex: M/F WT:______lbs.

Why are you having the exam? (Symptom):____

What side, location, body part is involved? (Location):____________________________________

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

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

YES NO Have you ever had a reaction to CT contrast?

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 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 Any prior imaging of the area? Where/when? ______________________________
YES NO Any prior surgery of the area? Type/dates?________________________________
YES NO Have you ever had arthroscopy on the area being scanned?
YES NO Have you had an injection of the area being scanned?
YES NO Have you ever had any other imaging studies done of the area being scanned?
If yes, what test/what area? ____________________

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:____

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Technologist Initials:________________