Northwestern Memorial® Hospital

Outpatient Computed Tomography
Patient History Questionnaire

(Please Print)

Name _____ Date _____ Medical Record # _____

Date of Birth _____ Weight (pounds) _____ Account # _____

Part of the body to be scanned _____

Have you ever had contrast (dye) injected before? ☐ Yes ☐ No Was there any problem? ☐ Yes ☐ No

If yes, please describe the problem _____

Have you fallen in the past three months? ☐ Yes ☐ No

Have you had a barium study in the past two weeks? ☐ Yes ☐ No

	Yes	No	Unsure	Not Applicable
Do you take Metformin (Glucophage® or Glucovance®)?	☐	☐	☐	
Do you use a continuous insulin pump?	☐	☐	☐	
Are you pregnant or trying to get pregnant?	☐	☐	☐	☐
Are you breastfeeding?	☐	☐	☐	☐

	Yes	No	Unsure
Do any of the following apply to you?	☐	☐	☐
Diabetes mellitus	☐	☐	☐
Heart problems (i.e. heart attack) _____	☐	☐	☐
High blood pressure	☐	☐	☐
Lung disease (i.e. asthma, emphysema) _____	☐	☐	☐
_____			
Kidney disease _____	☐	☐	☐
Neurological problems (i.e. seizures or stroke)	☐	☐	☐
_____			
_____			
Liver Disease _____	☐	☐	☐
Sickle cell disease	☐	☐	☐
Anemia	☐	☐	☐
Multiple myeloma	☐	☐	☐
Organ or marrow transplant	☐	☐	☐
Current or former cigarette smoker	☐	☐	

If yes, packs per day _____ and how many years smoked? _____

Have you ever had cancer? _____ If yes, what kind and did it spread to other areas? _____

Describe any imaging tests, surgeries, or procedures you have had performed in the area that is being scanned.

_____

What did the above tests, surgeries or procedures show? _____

_____

In your own words, why is this test being performed today? _____

_____

_____

Patient Signature _____ Date _____

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