CT SCREENING FORM (Non-Contrast)

Patient Name: Date:

Please review and answer the following questions:

Have you ever been diagnosed with cancer? .... ☐ Yes ☐ No
If yes, what type?

Have you had chemotherapy? ☐ Yes ☐ No If so, date of last dose?

Do you have multiple myeloma, sickle cell disease, pheochromocytoma? .... ☐ Yes ☐ No

Do you have kidney disease? .... ☐ Yes ☐ No

Do you have diabetes? .... ☐ Yes ☐ No

Do you have a Port or PICC line? .... ☐ Yes ☐ No

Are you receiving antibiotic therapy? .... ☐ Yes ☐ No

Do you have a neurostimulator, or a deep brain stimulator? .... ☐ Yes ☐ No

Please list all surgeries of the area being scanned:

Have you had previous CT exams? .... ☐ Yes ☐ No
If yes, at what facility?

Weight:

Female Patients Only

Is there any chance you could be pregnant? .... ☐ Yes ☐ No
Date of last menstrual period:
Are you currently breastfeeding? .... ☐ Yes ☐ No

Patient Signature: Date:

TECHNOLOGIST USE ONLY

Technologist's Notes: ____

Technologist's Name: ______________________________ Date: ____________