UNIVERSITY DIAGNOSTIC INSTITUTE
CT SCREENING QUESTIONAIRE

Date ______________________ Date of Birth ______________________

Name ____

Sex ____________ Age ____________ Weight ____________

Please list all surgeries ____

____

List allergies ____

Are you diabetic? ________ If yes, list all medication pertaining to diabetes: ______________

____

Do you have a history of cancer? ________ If yes, please describe: ______________

____

Are you on dialysis? ____________

Are you being treated for chronic kidney disease? ____________

Are you diabetic? ____________

Do you have a history of kidney disease, kidney cancer or kidney transplant? ______

____

Please answer to the following:

YES	NO	
_______	_______	Pregnant (Date of LMP: ________)
_______	_______	Vascular access port
_______	_______	Liver disease
_______	_______	Kidney disease
_______	_______	Renal function disorders
_______	_______	Blood disease or disorders
_______	_______	Anemia
_______	_______	Sickle cell anemia
_______	_______	Multiple myeloma
_______	_______	Pheochromocytoma (adrenal gland disease)
_______	_______	Cardiac pacemaker
_______	_______	Implanted orthopedic items (pins, rods, screws, plates, clips or artificial limbs or joints)

I attest that the above information is correct and accurate to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient's Signature ______________________ Date ______________

If minor, guardian signature

MD or RT Signature ______________________ Date ______________

**** PLEASE REMOVE ALL JEWELRY BEFORE YOUR EXAM****