CT Questionnaire – **Spine**

Name: _____ D.OB.___/___/___ Age: ____ Sex: M/F
(Last) (First)

WT: ____ HT:__ft. __in. Referring Physician: _____

- Please provide a summary of your symptoms specific to your exam today:_____
  _____
- The symptoms primarily involve what part of your body?_____
  If applicable, please circle: RIGHT or LEFT or BOTH sides of your body and/or Upper or Lower part of abdomen.
- Have you had a biopsy on this area? Yes___ No___ If so, what were the results?_____
- Did this symptom/condition arise suddenly? Yes___ No___ When did the problem start?_____
- How long have you been treated for this problem?_____ Circle if problem is **Chronic** or **Acute** or **Temporary**
- Is this your initial visit or follow-up visit?_____
- What is/was the cause of the problem? Accident / Motor Vehicle / Fall / Work-Related Injury (Complete Injury Form)
- Are you having pain? Yes___ No___ If Yes circle if pain is severe / moderate / mild
  If yes, circle if pain is generalized or localized. If localized pain, describe specific area of pain_____
- Do you have any weakness or numbness? Yes___ No___ If yes where?_____
- Do you have any of the following: swelling / bruising / inflammation / contusion / sprain / open wound (please circle)
- Did any existing disease/condition attribute to this current symptom? _____
- Do you have a history of being diagnosed with cancer? Yes ___ N0___ When?_____ Type?_____
- Have you been treated with either Radiation or Chemotherapy? (If yes, circle) Date started_____ Completed_____
- Any surgery on your spine? Yes___ No___ If yes, when and what type?_____
  _____
- Have you had a spinal injection? Yes___ No___ When?_____ Type?_____
- Any other medical or family history pertaining to your exam being performed today?_____
  _____
- Do you have any known allergies?:_____
- Are you pregnant or possibly pregnant? Yes___ No___ Date of last menstrual period_____
- Prior Diagnostic Imaging of the area being scanned? Yes___ No___ If yes, Date/Study/Facility_____
  _____

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.

Patient's signature: _____ Date: ___/___/___Technologist Initials: _____