Princeton Radiology
Excellence in Imaging

CT Spine Questionnaire

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:_____
  _____
- 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
- Do you have a history of being diagnosed with cancer? Yes ____ No____ When?_____ Type?_____
- Have you been treated with either: ☐ Radiation or ☐ Chemotherapy? Date started_____ Completed_____
- Have you taken a drug call **AVASTIN**? ☐ YES ☐ NO *If Yes, when was the last time your received the drug AVASTIN?* _____
- Do you wear a Dexcom glucose monitor? Yes ___ No ___ ***If Yes, please inform your technologist before exam***
- Any surgery on area being imaged? Yes____ No____ If yes, when and what type?_____
- Prior Diagnostic Imaging of the area being scanned today? Yes____ No____
  If yes, Date/Study/Facility_____
- Do you have any weakness or numbness? Yes _____ No _____ If yes, where? _____
- Which side of your body do your symptoms effect? ☐ Right ☐ Left ☐ N/A
- Have you had a spinal injection? Yes _____ No_____ When: _____ What type: _____

Female patients:

- Are you pregnant or possibly pregnant? Yes____ No____ Date of last menstrual period_____

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: _____

TECHNOLOGIST NOTES: _____

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