MUNSON HEALTHCARE

FORM# 8997 (12/18)

CAT SCAN SCHEDULING QUESTIONNAIRE

Date: _____

Patient Name:_____

Date of Birth:_____ **Insurance:** _____ **Current Weight:** _____

Are you allergic to iodine, x-ray contrast, or heart cath imaging contrast? ☐ Yes ☐ No

If yes, what are your symptoms:_____

_____

IF YES TO ANY IN THIS BOX, RECENT GFR WITHIN 30 DAYS PRIOR TO SCHEDULING		
Age greater than 60 years?	☐ Yes	☐ No
History of renal disease?	☐ Yes	☐ No
Dialysis?	☐ Yes	☐ No
Kidney transplant?	☐ Yes	☐ No
Single kidney?	☐ Yes	☐ No
Renal cancer?	☐ Yes	☐ No
Renal surgery?	☐ Yes	☐ No
History of hypertension?	☐ Yes	☐ No
Taking medication for hypertension?	☐ Yes	☐ No
Diabetic?	☐ Yes	☐ No

Do you have a history of **congestive heart failure**? ☐ Yes ☐ No

Do you have a history of **cancer/tumor** on the area to be scanned? ☐ Yes ☐ No

If yes, what kind?_____

Have you had a **prior surgery** on the area to be scanned? ☐ Yes ☐ No

If yes, what type?_____

Have you had any **previous radiology studies** on the area to be scanned? ☐ Yes ☐ No

If yes, what exams? (i.e., ultrasound, MRI, x-ray, etc.)_____

Where were they done?_____

Is this scan for an **injury/trauma or pre-surgical**? ☐ Yes ☐ No

If yes, please specify date: _____

Do you have any **special needs**? ☐ Yes ☐ No
(i.e., IV therapy, hoyer lift, interpreter, wheel chair, or assistance)

If yes, please specify: _____