CT/CTA Screening Form

Name: DOB: Age: Weight: Height: Sex:

Reason you are here today? Explain your medical problem in detail.

Patient History

	Question	Select Yes or No
1	Have you had previous exams related to your symptoms? If Yes- When:_____ Where:_____	☐ YES ☐ NO
2	Have you had surgery to the body part being imaged? If yes, please describe:_____	☐ YES ☐ NO
3	Do you have history of Cancer or Tumors? If yes, please describe:_____	☐ YES ☐ NO
4	Is there a chance you may be pregnant? Date of last menstrual period:_____	☐ YES ☐ NO ☐N/A
5	Do you have personal or family history of heart disease? If yes-Who:_____ What type:_____	☐ YES ☐ NO
6	Do you have hypertension or high blood pressure?	☐ YES ☐ NO
7	Do you have high cholesterol?	☐ YES ☐ NO
8	Do you have a history of smoking? (Past or Present) If yes, please describe:_____	☐ YES ☐ NO
9	Do you live an active lifestyle? (at least 30-60 minutes per day)	☐ YES ☐ NO
10	Are you diabetic?	☐ YES ☐ NO

I acknowledge that all the information given is accurate and thereby consent to have the CT procedure performed on me.

Signature of Patient or Authorized Representative Date

Charter Radiology Technologist Date