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CAT SCAN QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____
MRN: _____ Date of Test: _____
Allergies: _____

1. Why has your doctor sent you for this test? Did he/she give you a specific diagnosis?
   _____
   _____
   _____
2. Please describe what specific complaints/symptoms you are having:
   _____
   _____
   _____
3. How long have you had these complaints/symptoms?
   _____
4. Did these symptoms come on suddenly or gradually?
   _____
5. These complaints/symptoms have (*select one*):
   ☐ Improved ☐ Remained the Same ☐ Gotten Worse
6. Have you had an Appendectomy (*Appendix Removed*)? ☐ Yes ☐ No
7. Have you had any previous surgeries? ☐ Yes ☐ No If yes, what kind?
   _____
8. Have you had any of the following in the past or present?
   ☐ Diabetes
   ☐ Cancer (If so, describe _____)
   ☐ Chemotherapy (If so, for what? _____)
   ☐ Radiation Therapy (If so, for what? _____)
9. Do you have any of the following problems or symptoms?

☐ Fainting	☐ Headaches	☐Heartburn	☐ Coughing
☐ Constipation	☐ Bleeding	☐ Dizziness	☐ Shunt
☐ Cysts	☐ Difficulty Breathing	☐ Unconsciousness	☐ Fibroids
☐ Blood in Stool	☐ Diarrhea	☐ Blood in Urine	☐ Pain
☐ Seizures	☐ Heart Disease		
☐ Other_____			

10. Have you had prior CT Scans for these problems? ☐ Yes ☐ No If yes, include location and results:
    _____
    _____
    _____