

**UNIVERSITY DIAGNOSTIC INSTITUTE
CT SCREENING QUESTIONNAIRE**

Date _____ Date of Birth _____

Name _____

Sex _____ Age _____ Weight _____

Please list all surgeries _____

List allergies _____

Are you diabetic? _____ If yes, list all medication pertaining to diabetes: _____

Do you have a history of cancer? _____ If yes, please describe: _____

Please answer to the following:

YES	NO	
_____	_____	Pregnant (Date of LMP: _____)
_____	_____	Vascular access port
_____	_____	Liver disease
_____	_____	Kidney disease
_____	_____	Renal function disorders
_____	_____	Blood disease or disorders
_____	_____	Anemia
_____	_____	Sickle cell anemia
_____	_____	Multiple myeloma
_____	_____	Pheochromocytoma (adrenal gland disease)
_____	_____	Cardiac pacemaker
_____	_____	Implanted orthopedic items (pins, rods, screws, plates, clips or artificial limbs or joints)

Are you on dialysis? _____

Are you being treated for chronic kidney disease? _____

Are you diabetic? _____

Do you have a history of kidney disease, kidney cancer or kidney transplant? _____

I attest that the above information is correct and accurate to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient's Signature _____ Date _____

If minor, guardian signature

MD or RT Signature _____ Date _____

**** PLEASE REMOVE ALL JEWELRY BEFORE YOUR EXAM ****