Orlin & Cohen Medical Specialists Group

Computed Tomography (CT)

( ) Garden City ( ) Kew Gardens

CT SCAN IMAGING QUESTIONNAIRE

Please print:

Patient's Name ________________________________, ______________________________
LAST FIRST

DOB __________________ Age _____ Weight _______ ACCOUNT # __________________

Please answer the following questions:

What problems lead you to this exam? ____

How long have you had this problem? ___________ Any injury to this area? ____________________________

Have you had any surgery on this body part? Yes or No? ______If Yes, What type of surgery_________________

Do you have any implants – such as Pacemaker, Stents, Aneurysm clips? _______________________________

Have you had other Radiology tests for this problem such as MRI, Xray or CT? If yes, where? _______________

FEMALE PATIENTS: Date of Last Menstrual Cycle __________________

As of today, is there any possibility that you are pregnant? Yes ( ) or No ( )

PATIENT SIGNATURE: __________________________________

Name ____________________________________ Relationship to patient ______________________
(If signed by anyone but patient)

Date ___/____/____ CT OF ___________________ DR/Location ___________________ Patient's Initials _____

Date ___/ ____/ ____ CT OF ___________________ DR/Location ___________________ Patient's Initials _____

Date ___/ ____/ ____ CT OF___________________ DR/Location ___________________ Patient's Initials _____