Orlin&Cohen Orthopedic Group
An affiliate of Northwell Health

CT SCAN IMAGING QUESTIONNAIRE

Patient Name: _____, _____
(Please print) Last First

Date of Birth: _____/____/_____ Age: _____ Weight: _____ MRN: _____

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? Yes ( ) or No ( )

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 _____

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CT SCAN SAFETY SCREENING FORM

Patient Name: _____, _____

Last Name First Name

Body part being scanned: _____ ❑Left ❑Right

Weight_____ Height _____ft._____in. DOB: _____ MRN: _____

Please complete this form accurately and carefully

What problem lead you to this exam? _____

How long have you had this problem? _____

Was there any injury to this area? _____

Do you have any implants? Pacemaker, Stents, Aneurysm clips? _____

Have you had any surgery on this body part? _____If yes, what type of surgery ?_____

Have you had other tests for this problem such as MRI, X-Ray, or Cat Scan? _____ If so, where? _____

Female patients: Is there any possibility that you may be pregnant? ❑YES ❑NO

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

_____ _____ _____

Patient Signature Print Date

_____ _____ _____

Relative/Guardian Relationship to Patient MRN #

Date___/___/___ Scan_____ DR/Location _____ Patient's Initials _____

Date___/___/___ Scan_____ DR/Location _____ Patient's Initials _____