Princeton Radiology
Excellence in Imaging

CT Chest Questionnaire

Name:_____ D.O.B.___/___/____ Sex: M/F WT:_____lbs.

☐ ***YES NO*** ☐ ***Have you received a COVID vaccine? If yes, please answer the following: Pfizer/Moderna/J&J***
1st dose date: _____ ***Arm: RIGHT / LEFT 2nd dose date:*** _____ ***Arm: RIGHT / LEFT***

Why are you having the exam? (Symptom):_____

What side, location, body part is involved? (Location):_____

How long have you had this problem? (Duration):_____

If due to injury, how did it occur? (Mechanism of Injury):_____

☐ YES NO ☐ Is there any chance you may be pregnant? Date of last menstrual period?_____

☐ YES NO ☐ Do you wear a Dexcom, Libre, or other glucose monitor?

☐ YES NO ☐ Do you have unexplained fever?

☐ YES NO ☐ Are you immunocompromised? If uncertain, select NO.

☐ YES NO ☐ Do you have a history of being diagnosed with cancer? Type?_____

☐ YES NO ☐ Any radiation therapy? If YES, dates?_____

☐ YES NO ☐ Any chemotherapy? If YES, dates/type?_____

☐ YES NO ☐ Are you in a lung cancer screening program with yearly CTs of the chest?
☐ YES NO ☐ Do you now or have you ever smoked?
If YES, how many years did you smoke? _____ years
How many packs per day did you smoke? _____ packs per day
How long ago did you quit? If still smoking, mark as "0": _____ years ago

☐ YES NO ☐ Have you had a previous CT (any type) or cardiac nuclear medicine (myocardial perfusion) study in the past 12 months? If YES, what/how many: _____

☐ YES NO ☐ Did you have any prior imaging of the area being scanned in another imaging facility?
If YES, where/when? _____

☐ YES NO ☐ Any prior surgery of the area? Type/dates?_____

I acknowledge that all the information given is accurate and thereby consent to have CT with or without an injection of contrast performed on me.

Signature:_____ Date:___/___/___

Technologist Notes: _____

_____

Technologist Initials:_____