

CT Spine Questionnaire

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

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 Have you had a spinal injection? What type? _____

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? _____

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 currently have an inferior vena cava (IVC) filter placed in your body?

YES NO If yes above, is there a plan in place to remove the filter?

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

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: _____