ADVANCED SHORE IMAGING ASSOCIATES

Advanced Shore Imaging Associates
2605 Shore Road
Suites 101 & 201
Northfield NJ 08225

Exam Date:

CT Questionnaire

Patient / MRN: _____ **D.O.B.** _____

Exam: _____ **Technologist** _____

1. Patient Weight		
2. Does your script say with or W/O contrast or is it not specific?	YES ☐	NO ☐
3. Are you a current smoker?	YES ☐	NO ☐
4. Have you quit smoking within the past 15 years?	YES ☐	NO ☐
5. Do you have a smoking history of 30 pack years or greater? (Pack year = someone who has smoked an average of 1 pack Of cigarettes per day for one year. Same as smoking 2 packs Per day for 15 years)	YES ☐	NO ☐
6. Are you a diabetic?	YES ☐	NO ☐
7. If yes – what meds do you take?	YES ☐	NO ☐
8. Any Surgery?	YES ☐	NO ☐
9. If Yes – what kind		
10. Any renal/kidney problems?	YES ☐	NO ☐
11. If so describe them:		
12. Lab Date of most recent lab work?		
13. BUN		
14. CREATININE		
15. GFR		
16. Any chance of pregnancy?	YES ☐	NO ☐
17. Previous Iodine injection?	YES ☐	NO ☐
18. Any reaction to Iodine injection?	YES ☐	NO ☐
19. Any Allergies?	YES ☐	NO ☐
20. Any asthma or inhaler use?	YES ☐	NO ☐
21. Any diagnosed seizure disorder?	YES ☐	NO ☐
22. Do you have any special needs?	YES ☐	NO ☐
23. If yes please describe them:	YES ☐	NO ☐
24. Are you able to get on/off exam table with minimal assistance?	YES ☐	NO ☐

Comments:

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

Signature
(Patient, Parent or Guardian) _____ **Date** _____