



**NYU Trinity Center**  
 111 Broadway, 2<sup>nd</sup> Floor  
 New York, NY 10016  
 Telephone: (212) 263-9700  
 Facsimile: (212) 263-9701

**CT Scan Questionnaire**

Chest  
 Abdomen  
 Head/Neck

Name:		Today's Date:	
Date of Birth:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Doctor:
What complaints or symptoms lead you to seek medical attention?			
How long have you had these symptoms?		Have the symptoms changed? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Are you being treated for any other medical problems? <i>If so, please list</i> <input type="checkbox"/> No <input type="checkbox"/> Yes			
Are you currently taking any medications? <i>If so, please list</i> <input type="checkbox"/> No <input type="checkbox"/> Yes			
Please indicate allergies:			
Have you had anything to eat or drink in the last 3 hours?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Any chance of pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A		Are you currently breastfeeding? <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Important – Please Answer:</b>			
Do you have an allergy to shellfish? <input type="checkbox"/> No <input type="checkbox"/> Yes		Do you have heart disease? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have kidney disease? <input type="checkbox"/> No <input type="checkbox"/> Yes		Do you have asthma? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have diabetes? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Have you ever had surgery? <i>If so, please list</i>		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Have you had previous CT scan(s)?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, what type?		<input type="checkbox"/> Abdomen <input type="checkbox"/> Chest <input type="checkbox"/> Other <i>specify</i> _____	
If yes, where?		<input type="checkbox"/> Trinity <input type="checkbox"/> NYU Medical Center <input type="checkbox"/> Other <i>when</i> _____	
Do you know the interpretation or diagnosis? <i>If so, please list</i> <input type="checkbox"/> No <input type="checkbox"/> Yes			
Have you had an x-ray that required an iodine contrast injection into a vein?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, did you have any reaction to this injection?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Have you ever received radiation treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes		Chemotherapy treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>STAFF USE ONLY:</b>		<b>Reasons for non-ionic use:</b>	
Comments:		Previous reactions <input type="checkbox"/>	
		Asthma <input type="checkbox"/>	
		Allergic History <input type="checkbox"/>	
		Cardiac Dysfunction <input type="checkbox"/>	
		Sickle Cell <input type="checkbox"/>	
		Severe Debilitation <input type="checkbox"/>	
		None of the Above <input type="checkbox"/>	