Dartmouth-Hitchcock
MEDICAL CENTER

CT Questionnaire

To Schedule CT
Call (603) 650-8445

Scan Date: _____ **Scan Time:** _____

Patient Name: _____

MRN: _____

Age: _____ **DOB:** _____

Answers provided by: Patient / Family Member ***(circle one)***

Body Part to be examined _____

Referring Provider: _____ Office phone/Secretary: _____

MRI RISKS ***(Please ask the Patient ALL of the following questions)***

What is the patients current weight?

Has the patient ever had a reaction to X-Ray dye?	Yes		No	
Does the patient have a Medi Port?	Yes		No	
Is patient diabetic / taking oral hypoglycemic?	Yes		No	
Has patient ever been told they have renal problems?	Yes		No	
Has patient ever been told they have protein in their urine?	Yes		No	
Has patient ever had kidney surgery?	Yes		No	
Does patient have high blood pressure?	Yes		No	
Does patient have gout?	Yes		No	
Is the patient coming from a skilled care facility? ***If yes, caregiver must stay w/ patient during entire exam***	Yes		No	
Does patient have any mobility limitations (i.e. spinal precautions)?	Yes		No	

IS THE PATIENT TAKING ANY OF THE FOLLOWING ORAL HYPOGLYCEMICS?

Actoplus Met	Yes		No		PrandiMet	Yes		No	
Avandamet	Yes		No		Fortamet	Yes		No	
Glucovance	Yes		No		Glucophage	Yes		No	
Janumet	Yes		No		Glumetza	Yes		No	
Jentadueto	Yes		No		Riomet	Yes		No	
Kombiglyze	Yes		No		Metformin	Yes		No	
Metaglip	Yes		No						

ADDITIONAL INFORMATION: _____

_____

Questionnaire Completed By: _____ **Date:** _____