

# Carolina Neurosurgery & Spine Associates, P.A.

## CT Patient Screening Form

Exam Date \_\_\_\_/\_\_\_\_/\_\_\_\_      Ordering Physician \_\_\_\_\_      MR# \_\_\_\_\_

Name \_\_\_\_\_      Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_      Male / Female  
Last name      First name      Middle Initial      MM / DD / YY      (circle one)

Weight \_\_\_\_\_ lbs.      Describe your symptoms: \_\_\_\_\_

(symptoms continued) \_\_\_\_\_

**Prior exams:**

Have you had prior diagnostic imaging study or examination (MRI, CT, X-ray, Ultrasound, etc.)? **YES / NO**  
 If yes, please list type of exam(s), body part, date of exam and facility:

**YES / NO**      Have you ever had cancer? If YES, what type and when? \_\_\_\_\_

**YES / NO**      Have you had radiation treatments? If YES, when was your last treatment? \_\_\_\_\_

**YES / NO**      Have you had chemotherapy? If YES, when was your last treatment? \_\_\_\_\_

**YES / NO**      Have you had a recent fever or infection? Please explain \_\_\_\_\_

**Circle any of the health problems that YOU have had or now have:**

- |                            |                      |                            |                       |                    |
|----------------------------|----------------------|----------------------------|-----------------------|--------------------|
| * Asthma                   | * Diabetic           | * Kidney Disease (failure) | * Heart Attack        | * Pheochromocytoma |
| * Heart Disease            | * Sickle Cell Anemia | * Myesthenia Gravis        | * Emphysema           |                    |
| * Congestive Heart Failure | * Multiple Myeloma   | * Lupus                    | * Angina (chest pain) |                    |

**Circle any of the following surgeries that YOU have had:**

- |                 |               |                |           |               |
|-----------------|---------------|----------------|-----------|---------------|
| * Appendectomy  | * Gallbladder | * Sinuses      | * Breast  | * Spine _____ |
| * Heart         | * Lung        | * Hysterectomy | * Bladder |               |
| * Ovaries       | * Stomach     | * Kidney       | * Thyroid | * Brain _____ |
| * Hernia repair | * Pancreas    | * Colon        |           |               |

**Please list any other surgeries not listed above:**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_      Type of surgery \_\_\_\_\_

**For female patients:**

Date of last menstrual period: \_\_\_\_/\_\_\_\_/\_\_\_\_      Post menopausal? **YES / NO**  
 Are you pregnant or experiencing a late menstrual? **YES / NO**

\*\*\*\*\*  
 I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the CT procedure I am about to undergo.  
 I hereby authorize Carolina Neurosurgery & Spine Associates, P.A. to release insurance information to Charlotte Radiology for billing purposes associated with the interpretation /reading of my CT examination. I understand that I will receive two separate charges for this procedure; one for the CT examination and one for the interpretation/reading.

Signature \_\_\_\_\_      Relationship to patient \_\_\_\_\_      Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Technologist Signature \_\_\_\_\_      Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Office Use Only**

Exam: \_\_\_\_\_      Diagnosis: \_\_\_\_\_      Amount of Contrast (if used): \_\_\_\_\_ cc's

Technologist Notes: \_\_\_\_\_