CAROLINA
NeuroSurgery & Spine
ASSOCIATES

CT SCREENING FORM

Exam Date _____ Ordering Physician: _____

Name: _____ MRN: _____

DOB: _____ ☐Male ☐Female Weight: _____lb.

Describe your symptoms: _____

_____

Prior Exams:

Have you had prior diagnostic imaging study on your body (MRI, CT, X-Ray, Ultrasound, etc.)? ☐Yes ☐No

If yes, please list the type of exam(s), body part, date of exam and facility: _____

_____

☐Yes ☐No Have you ever had cancer? If YES, what type & when?

_____

☐Yes ☐No Have you had radiation treatments? If YES, when was your last treatment?

_____

☐Yes ☐No Have you ever had chemotherapy? If YES, when was your last treatment?

_____

☐Yes ☐No Have you had a recent fever or infection? Please explain:

_____

Check all the health problems *YOU* have had or are now experiencing:

☐Asthma	☐Diabetes	☐Emphysema	☐Pheochromocytoma	☐Heart Attack
☐Heart Disease	☐Sickle Cell Anemia	☐Myasthenia Gravis	☐Congestive Heart Failure	
☐Lupus	☐Angina (chest pain)	☐Multiple Myeloma	☐Kidney Disease (failure)	

Check all surgeries *YOU* have had:

☐Heart	☐Gall Bladder	☐Sinuses	☐Appendectomy	☐Hernia Repair
☐Breast	☐Heart	☐Lung	☐Hysterectomy	☐Bladder
☐Ovaries	☐Stomach	☐Kidney	☐Brain:	
☐Thyroid	☐Colon	☐Pancreas	☐Spine:	

List any additional surgeries? _____ Date: _____

For Female Patients

Are you pregnant or experiencing a late menstrual period? ☐Yes ☐No

Date of last menstrual period: _____ Post-menopausal? ☐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 CR 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

_____ _____

Signature of Technologist Date

Office Use Only

Exam: _____ Diagnosis: _____ Amount of Contrast (if used): _____ccs

Technologist Notes: _____