Santa Cruz Comprehensive Imaging

CT Clinical Information Questionnaire

Patient Name:_____ MRN:_____

What problem(s) brought you to the doctor and resulted in this exam being ordered? ____

_____

_____

What do you think might have caused the problem and when did the problem start? _____

_____

_____

Are you pregnant ?	☐ **Yes**	☐ **No**
Have you had any previous surgery?	☐ **Yes**	☐ **No**
Have you had any other treatments (Including radiation or chemotherapy) on the part of your body that we are scanning today?	☐ **Yes**	☐ **No**
Have you had a prior related diagnostic imaging study or exam (MRI, CT, Ultrasound, X-ray, etc.)?	☐ **Yes**	☐ **No**

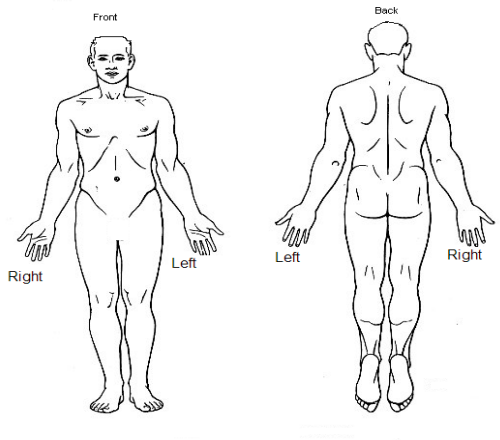
If you answered "Yes" to any of the questions above, please explain below:

Date:	**Type of Surgery, Treatment or Related Study:**
_____	_____
_____	_____
_____	_____
_____	_____

Please circle area(s) of pain and/ or Discomfort on the drawing. Draw arrows If pain extends from one area to another.

Please indicate symptoms using the following
Capital letters:

Dull ache = D
Sharp Pain = S
Numbness = N
Tingling = T



Signature of Patient_____ Today's Date_____