RADIOLOGY ASSOCIATES
OF ABILENE, P.A.

# CT PATIENT QUESTIONNAIRE

**PATIENT DETAILS:**

Patient Name: _____ DOB: _____

Medical Rec Number: _____ Referring Physician: _____

**STUDY DETAILS:**

Number of images: _____

Type of CT exam: _____ Date of exam: _____

Technologist: _____ Prior exams?: _____

**SYMPTOMS:**

☐ Pain Location: _____ Duration: _____

☐ Injury Severity: _____

☐ Leukocytosis ☐ Fever ☐ Nausea/vomiting

☐ Flank pain ☐ Hematuria ☐ Dyspnea ☐ Pos D-dimer

Other info: _____

**HISTORY:**

Known Diagnosis: _____ Prior Surgeries: _____

Known Cancer: _____ Anticoagulants: _____

**TECHNICAL ISSUES:**

Any problem/limitaion with this exam? _____

**RADIOLOGIST PRELIMINARY FINDING:**