ProHEALTH℠ Care
Part of OptumCare™
Imaging Services

For office use only	
Sch date:	Time:
Run date:	Time:
Ledge:	Initial:

CT scan or MRI question form
(Note: Use the mammography form for breast exams.)

Patient name: _____ Age: _____ Date of birth: ___/___/___

Sex: Male / Female / Transgender

Patient ID: _____ Date of service: ___/___/___

Referring doctor: _____ Referring doctor phone: _____

1. What problem brings you here today? _____

2. Please describe any surgeries you've had: _____

3. Have you ever had cancer? [ ] Yes [ ] No If yes, what type? _____
   List any treatments you've had (such as radiation, chemotherapy, etc.): _____

4. Have you ever have a CT or Cat Scan? [ ] Yes [ ] No
   If so, of what body part? _____

5. Have you ever been given IV contrast or X-ray dye before? [ ] Yes [ ] No
   If yes, did you have any problems? [ ] Yes [ ] No
   If yes, please explain? _____

6. Do you have any allergies? [ ] Yes [ ] No
   If yes, what are you allergic to and what's the reaction (bad effect)? _____

7. Do you have asthma? [ ] Yes [ ] No

8. Do you have diabetes? [ ] Yes [ ] No
   If yes, do you take medicine for your diabetes? [ ] Yes [ ] No
   If yes, what kind? [ ] Metformin (Glucophage®) [ ] Glyburide-metformin (Glucovance®)

9. Do you have kidney or heart problems? [ ] Yes [ ] No
   If yes, please explain: _____

10. Are you breast feeding? [ ] Yes [ ] No