607 Amboy Avenue
Perth Amboy, NJ 08861
TEL 732-442-5444
FAX 732-442-2626

PERTH AMBOY
DIAGNOSTIC IMAGING

CT HISTORY QUESTIONNAIRE

1. What was your chief complaint when you visited your doctor?
____
____
____
2. Have you ever had any surgery? □Yes □No
____
____
____
3. Do you have any allergies, asthma, or hay fever? □Yes □No
____
____
____
4. Do you have any allergies to food containing iodine such as fish, shellfish, or seafood of any kind? □Yes □No
____
____
____
5. Have you ever had any allergic reaction to any medicine containing iodine such as injections for kidney tests (IVP Dye), cat scans or angiograms? □Yes □No
____
____
____

6. Do you have:	Yes	No
High Blood Pressure	□	□
Diabetes	□	□
Heart Disease	□	□
Sickle Cell Anemia	□	□
Kidney Disease	□	□
7. Are you pregnant	□	□

8. List all medications:
____
____
9. Are you taking Glucophage? □ Yes □No

ıereby give permission to contact my physician or health care facility for prior ›ports or films relating to this exam.

Patient's Signature ____________________

Open & Highfield MRI • CT-Scan • Nuclear Medicine • Ultrasound • DEXA Scan • Digital Mammography • Digital X-Ray

Comprehensive diagnostic imaging made comfortable and convenient.