CAMPBELLFORD MEMORIAL HOSPITAL

C.T. QUESTIONNAIRE

Your personal health infromation will only be disclosed to other care providers involved within your circle of care unless you have expressly withheld or withdrawn your consent to do so.

Patient's Name:_____

Information we request here is very important to your examination -- **Please circle either "YES" or "NO" for every question**

What is the reason for the CT Scan? _____

No	**Yes**	Do you have an allergy to X-Ray Dye?
No	**Yes**	Have you ever smoked cigarettes? If yes, ____ packs per day, last cigarette in the year _____
No	**Yes**	Have you ever been exposed to asbestos? Where? _____
No	**Yes**	Have you had radiation therapy for cancer? What for? _____ What year? _____
No	**Yes**	Have you had leukemia or lymphoma? What year was it diagnosed? _____ What was the site? _____
No	**Yes**	Do you have Multiple Myeloma?
No	**Yes**	Have you had melanoma? Where? _____ What year was it diagnosed? _____
No	**Yes**	Have you had breast cancer? What year? _____
No	**Yes**	Have you had brain surgery? What for? _____ What year? _____
No	**Yes**	Have you had neck surgery? What for? _____ What year? _____
No	**Yes**	Have you had lung surgery? What for? _____ What year? _____
No	**Yes**	Has your gall bladder been removed?_____ What year? _____
No	**Yes**	Has your appendix been removed?_____ What year? _____
No	**Yes**	Have you had surgery on your liver or spleen? What for? _____ What year? _____
No	**Yes**	Have you had surgery on your pancreas? What for? _____ What year? _____
No	**Yes**	Have you had surgery on your stomach or bowel? What for? _____ What year? _____
No	**Yes**	Have you had surgery on your kidneys or bladder? What for? _____ What year? _____
No	**Yes**	Do you have kidney disease? What disease? _____
No	**Yes**	Have you had an aneurysm repaired? Where? _____ What year? _____
No	**Yes**	Have you had any heart surgery? Where? _____ What year? _____
No	**Yes**	Have you had any surgery or cancer in your pelvic organs (uterus {hysterectomy}, ovaries, testicles, prostate)?
		Organ(s) _____ Reason _____ Year _____
No	**Yes**	Is there any chance you could be pregnant?
No	**Yes**	Is there any other information about your health we should know? Please specify below.
		_____

Print Name: _____ Date: _____

Signature: _____

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