inspired spine

CT Patient Questionnaire

Patient Name **Birth Date** **MRN**

1. Briefly describe your current symptoms and how long you've been experiencing those symptoms:

2. Check all of the following symptoms you are experiencing:

- ☐ Pain
- ☐ Swelling
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Urinary Problems
- ☐ Bloating
- ☐ Abdominal Pain
- ☐ Back Pain
- ☐ None of these

3. Have you had any previous testing for the symptoms you selected above? No Yes If YES, please describe testing below:

4. Please list the surgeries that you've had:

5. Have you ever had cancer? No Yes If YES, list type and diagnosis date below:

6. Have you ever had chemotherapy? No Yes If YES, when and what drugs were you given?

7. Have you ever had radiation therapy? No Yes If YES, what region of the body and when?

8. Are you a diabetic? No Yes If YES, what medication and when was your last dose?

9. Do you take Metformin? No Yes

10. Do you have allergies to medications, latex or contrast media? No Yes If YES, please list:

11. Have you had any recent infections? No Yes If YES, what type and when?

12. Are you a current or former smoker? No Yes If YES, how many packs per day and how many years have you smoked?

If you are a former smoker, when did you quit?

13. Do you have asthma? No Yes If YES, and you use an inhaler, what type and when was your last dose?

14. Are you claustrophobic? No Yes
15. Do you have any heart problems? No Yes
16. Do you have a history of multiple myeloma? No Yes
17. Do you have a history of kidney disease? No Yes
18. Have you had any recent vaccinations? No Yes If YES, please list:

19. What is your height? 20. What is your weight?