



CT & IVP QUESTIONNAIRE

- FREEHOLD**
 NEPTUNE
 BRICK/POINT PLEASANT

Jersey Shore Radiology
Doctors Park
900 West Main St.
Freehold, NJ 07728
Phone: 732-462-1900
FAX: (732) 462-1848

Jersey Shore Imaging
Medical Arts Bldg
2100 Corlies Ave.
Neptune, NJ 07753
Phone: (732) 988-1234
FAX: (732) 502-0368

Jersey Shore Radiology
River Medical Park
3822 River Road
Point Pleasant, NJ 08742
Phone: (732) 892-1200
FAX: (732) 892-1202

PATIENT INFORMATION

LAST NAME	FIRST / MI	DOB / /	AGE	PHONE #
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CURRENT SYMPTOMS

Please list/describe symptoms you are experiencing:

WEIGHT (LBS)	HEIGHT (FT., IN)
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Are you pregnant? YES / NO
Are you breast feeding? YES / NO
When was your last menstrual period? _____

HISTORY OF SURGERY

Have you had any surgeries in the past? YES / NO
 If YES, please list them and provide the dates they were performed:

PREVIOUS IMAGING STUDIES

Have you had any previous studies done pertaining to the body part being scanned today? YES / NO
 If YES, please list them and provide dates:

HISTORY OF CONTRAST

Have you ever had contrast, iodine, or dye for an x-ray, CT or heart catheterization? YES / NO
Are you allergic to iodine or contrast dye? YES / NO
Have you ever had an allergic reaction to iodine or contrast dye (i.e., IVP or CT dye)? YES / NO
 If YES, please explain the type of reaction _____

Do you have an allergy to latex? YES / NO

MEDICAL HISTORY

	CHECK IF APPLICABLE
Asthma	<input type="checkbox"/>
Do you use an inhaler?	Y / N
Other asthma medication?	Y / N
Emphysema	<input type="checkbox"/>
Urinary Tract Infection	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>
Myasthenia Gravis	<input type="checkbox"/>
Sickle Cell Anemia	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>
Anaphylactic Shock	<input type="checkbox"/>
Chemo/Radiation Therapy	<input type="checkbox"/>
Cancer	<input type="checkbox"/>
If CHECKED, what type? _____	
Diabetes	<input type="checkbox"/>
Smoker	<input type="checkbox"/>
Dialysis	<input type="checkbox"/>
Angina	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>
Lupus	<input type="checkbox"/>
Dehydration	<input type="checkbox"/>
Hyperthyroidism	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>
Abdominal Aortic Aneurysm	<input type="checkbox"/>
Pheochromocytoma	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>
History of Hives	<input type="checkbox"/>
Multiple Myeloma	<input type="checkbox"/>

CURRENT MEDICATIONS

	CHECK IF APPLICABLE
Glucophage	<input type="checkbox"/>
Glucovance	<input type="checkbox"/>
Metformin	<input type="checkbox"/>
Metaglip	<input type="checkbox"/>
Janumet	<input type="checkbox"/>
Avandamet	<input type="checkbox"/>
Actoplus	<input type="checkbox"/>
Fortamet	<input type="checkbox"/>
Riomet	<input type="checkbox"/>
Glumetza	<input type="checkbox"/>
Prandimet	<input type="checkbox"/>

If you are taking any other medication, please list them here:

PATIENT SIGNATURE	TECHNOLOGIST SIGNATURE	DATE OF EXAM / /
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