

MISSION IMAGING CENTER  
PATIENT QUESTIONNAIRE FOR CT AND X-RAY EXAMS

Patient's name \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_

Patient Account #: \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Symptoms/Diagnosis:  
\_\_\_\_\_

Have you had any previous exams of the area we are imaging? Yes \_\_\_ No \_\_\_  
If yes, please list the type of exam and where we can locate the exam.  
\_\_\_\_\_

Have you ever had an allergic reaction to x-ray contrast? Yes \_\_\_ No \_\_\_

Have you ever been diagnosed with Diverticulitis, Pancreatitis,  
bowel perforation, bowel obstruction or jaundice? Yes \_\_\_ No \_\_\_

Have you ever been diagnosed with cancer? Yes \_\_\_ No \_\_\_

If yes, please list type of cancer \_\_\_\_\_

Do you have Multiple Myeloma? Yes \_\_\_ No \_\_\_

Please list any food or drug allergies. \_\_\_\_\_

Do you have any disease of your kidneys or do you have  
Only one kidney? Yes \_\_\_ No \_\_\_

If Yes – please specify:  
\_\_\_\_\_

Are you diabetic? Yes \_\_\_ No \_\_\_

Have you had recent blood work? Yes \_\_\_ No \_\_\_  
If yes – where? \_\_\_\_\_

Are you currently taking Metformin, Glucophage, Glucophage XL,  
Glucovance, Avandamet, or Metaglip? Yes \_\_\_ No \_\_\_

Do you have any blood disease? Yes \_\_\_ No \_\_\_

Sickle Cell Anemia Yes \_\_\_ No \_\_\_

Polycythemia or Pheochromocytoma? Yes \_\_\_ No \_\_\_

Is there any chance that you may be pregnant or  
are you breast feeding? Yes \_\_\_ No \_\_\_

When was your last menstrual period? \_\_\_/\_\_\_/\_\_\_

**FOR OFFICE USE ONLY**

ORDER \_\_\_\_\_ Is in our office  
\_\_\_\_\_ Patient will bring  
\_\_\_\_\_ The Dr. Office will fax

Scheduled by: \_\_\_\_\_ Date: \_\_\_\_\_