CT COLONOGRAPHY

SJRA
SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete
DOS: _____

PATIENT #: _____
PATIENT NAME: _____
DOB: _____ / AGE: _____ / SEX: _____

*** **Please answer the following questions about your medical history to the best of your ability. Our Radiologists and staff will use the information you provide to select the most appropriate imaging techniques and to interpret the examination in order to best serve you! If you have any questions, please do not hesitate to ask.** ***

□ Yes □ No – Are you currently experiencing any gastrointestinal symptoms or symptoms related to the stomach or bowel?

WEIGHT:

If yes, please describe: _____

□ Yes □ No – Rectal bleeding
□ Yes □ No – Rectal cancer
□ Yes □ No – Colon cancer
□ Yes □ No – Colon polyps
□ Yes □ No – Ulcerative colitis
□ Yes □ No – Crohn's disease (regional enteritis)
□ Yes □ No – Diverticular disease/diverticulosis

□ Yes □ No – Have you had colon surgery? If yes, when? _____
Please describe the surgery: _____

□ Yes □ No – Have you ever had any radiation treatments to the pelvis area? If yes, when? _____
Why? _____

□ Yes □ No – Have you ever had a colonoscopy/sigmoidoscopy in the past? If yes, when? _____
What were the results? _____

□ Yes □ No – Do you have a family history of colon cancer?
If yes, please specify who: _____ Age at diagnosis: _____

□ Yes □ No – Do you have a personal history of any other cancer(s)? If yes, what type? _____
When were they diagnosed? _____

When was your last physical exam? _____ When was your last rectal exam? _____

FOR WOMEN: Date of last menstrual period: _____
Are you pregnant or think you could be? □ Yes □ No Have you had a hysterectomy? □ Yes □ No
Are you using any form of birth control? □ Yes □ No ---------- If yes, list: _____

TECHNOLOGIST USE ONLY

Comments: _____

_____CT Technologist:_____Ext:_____

Please list any allergies: _____

I attest that the information on the form above, including technologist comments above, is correct and complete to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the CT procedure that I am about to undergo.

Signature of Person Completing Form: _____ **Date:** _____

If Form Completed by Someone Other than the Patient (Print name): _____

Relationship: _____