

CT COLONOGRAPHY



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 – Ulcerative colitis

Yes No – Rectal cancer

Yes No – Crohn’s disease (regional enteritis)

Yes No – Colon cancer

Yes No – Diverticular disease/diverticulosis

Yes No – Colon polyps

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: _____