CIVA
THE CARDIOVASCULAR SPECIALISTS

CARRELL CLINIC CENTER, TOWER 1
SUITE 410, 9301 NORTH CENTRAL EXPWY.
DALLAS, TEXAS 75231

CIVA CT IMAGING | CT SCAN PATIENT QUESTIONNAIRE

Name: ____ Date of Birth: ______________ Sex _______
Today's Date _________ Height _______ Weight _____ Physician ___________________________
CT SCAN to be done today: ____
Pharmacy Phone Number: ____________________ Insurance Co. Name: ____________________

Please answer the following:

1. Have you had this procedure before? Yes ( ) No ( )
   If yes, where was it performed? ____
2. Please list any medical procedures you have had in the past year.

   ____

3. Are you pregnant? Yes ( ) No ( ) N/A ( )
   Date of last menstrual period, if applicable___________________

   By my signature on this form, I do hereby state to the best of my knowledge and belief, I
   - Am **NOT** pregnant.
   - Do **NOT** suspect pregnancy.
   - Am **NOT** breast-feeding.

   Signature ________________________________ Date ____________

4. Do you have a history of any of the following?

Heart disease	Yes ( )	No ( )	Vision problems	Yes ( )	No ( )
Radiation therapy	Yes ( )	No ( )	Hearing problems	Yes ( )	No ( )
Chemotherapy	Yes ( )	No ( )	Kidney problems	Yes ( )	No ( )
Hemodialysis	Yes ( )	No ( ), if yes, days of dialysis___________________			

5. Medicine allergies ___________________________________

6. Have you ever had an allergic reaction to dye, iodine or shellfish? Yes ( ) No ( )

7. Have you ever been diagnosed with diabetes? Yes ( ) No ( )

   If yes, are you taking pills or insulin? List medication name:

   ____

8. Do you take Levitra, Cialis, or Viagra? Yes ( ) No ( )

9. Please list all medications you are currently taking.

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