

PAIN SHEET

CT CHEST/ABDOMEN/PELVIS EVALUATION

| LAST NAME | FIRST | MIDDLE INIT. | AGE | TODAY'S DATE |
|-----------|-------|--------------|-----|--------------|
| | | | | |

1. Have you had an abdominal or pelvic ultrasound, chest X-ray, or previous CT scan of your chest, abdomen, or pelvis? _____ If yes, when? _____
2. What does your doctor say about what he/she thinks may be causing your problem? _____

3. Describe your symptoms (pain, mass, weight change, etc.) _____

4. Does anything make the symptoms worse? _____

5. Have you had chest, abdominal, or pelvis surgery? _____
When? _____ What was done? _____
6. Are you taking any medicines? _____ What kind? _____
7. Do you have any other medical conditions? If so, what? _____

8. Do you have food/drug allergies or asthma? _____
Have you ever had a reaction to X-ray dyes or contrast agents? _____
9. Is there any possibility you could be pregnant? Yes No
10. Are you a diabetic? Yes No