



**CT Questionnaire**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Body Part to be Examined: \_\_\_\_\_ Reason for MRI / Symptoms: \_\_\_\_\_

**1. Have you ever had prior surgery, operation, or procedure of any kind?** YES NO

<i>If yes, please list:</i>	<i>Side (Circle One)</i>	<i>Doctor</i>	<i>Date</i>	<i>Facility (if not sure give town)</i>
Type: _____	Left /Right/Both/NA _____	_____	_____	_____
Type: _____	Left /Right/Both/NA _____	_____	_____	_____
Type: _____	Left /Right/Both/NA _____	_____	_____	_____
Type: _____	Left /Right/Both/NA _____	_____	_____	_____

**2. Have you ever had a prior diagnostic imaging study or examination?** YES NO

<i>If yes, please list:</i>	<i>Body Part</i>	<i>Side (Circle One)</i>	<i>Date</i>	<i>Facility (if not sure give town)</i>
MRI	_____	Left / Right / Both / NA _____	_____	_____
CT	_____	Left / Right / Both / NA _____	_____	_____
X-ray	_____	Left / Right / Both / NA _____	_____	_____
Ultrasound	_____	Left / Right / Both / NA _____	_____	_____
Nuclear Med.	_____	Left / Right / Both / NA _____	_____	_____
Other	_____	Left / Right / Both / NA _____	_____	_____

- Is there any chance you may be pregnant? YES NO
  - When was your last menstrual period? \_\_\_\_\_
- Any personal history of cancer? YES NO
  - If so when, type, and treatment: \_\_\_\_\_

**If this is a joint CT please answer these questions:**

1. What is your chief complaint for visiting us today? \_\_\_\_\_  
\_\_\_\_\_
2. What does your doctor think is causing the problem? \_\_\_\_\_  
\_\_\_\_\_
3. Was this the result of an accident or injury? YES NO  
If yes, how long ago was your injury? \_\_\_\_\_  
Please describe what happened: \_\_\_\_\_  
\_\_\_\_\_
4. Do your symptoms involve a certain area of the joint? YES NO  
If yes, where? (inside, outside, front, back) \_\_\_\_\_
5. If there was no injury, are the symptoms related to overworking the joint as a result of your job, sport, or hobby? YES NO  
If yes, what specific motion does your activity require: \_\_\_\_\_
6. If you answered no to questions 3 and 5, what other known conditions do you think could account for your symptoms? (arthritis, cancer, e.g.) \_\_\_\_\_
7. Are your symptoms aggravated by any certain movement or activity? YES NO  
If yes, please describe: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Scheduler Initials: \_\_\_\_\_

## Consent to Release Confidential Patient Information to Coordinated Health

I, \_\_\_\_\_ (patient name), give my permission to \_\_\_\_\_ (name of organization) to release information from my medical record(s) to \_\_\_\_\_ (person) at Coordinated Health for the purpose of patient care.

Please send:

- All records from \_\_\_\_\_ to \_\_\_\_\_ (dates)  
 Radiographs  
 Laboratory  
 Physical therapy  
 Operative reports  
 Discharge summary  
 Radiology reports  
 Other (please specify) \_\_\_\_\_

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Social Security Number

If the patient is a minor, mentally or physically disabled, or deceased, the legally responsible party should sign and date this consent.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Relationship to Patient

*Surgical Specialty Center • Orthopedic Center • Back and Neck Center • Minimally Invasive Spine Center • Hand and Wrist Center  
• Foot and Ankle Center • Imaging Center • Rehabilitation Center • Plastic Surgery Center • Arthritis & Osteoporosis Center*

<input type="checkbox"/> CH Allentown	1401 N. Cedar Crest Blvd	Allentown, PA 18104	Phone 610-433-8080	Fax 610-433-4376
<input type="checkbox"/> CH Surgical Specialty Center	2310 Highland Avenue	Bethlehem, PA 18020	Phone 610-691-4300	Fax 610-691-6257
<input type="checkbox"/> CH Bethlehem / Corporate	2775 Schoenersville Road	Bethlehem, PA 18017	Phone 610-861-8080	Fax 610-861-2989
<input type="checkbox"/> CH Highland	2300 Highland Avenue	Bethlehem, PA 18020	Phone 610-865-4880	Fax 610-997-7171
<input type="checkbox"/> CH Easton	400 S. Greenwood Avenue	Easton, PA 18045	Phone 610-515-8080	Fax 610-515-8080
<input type="checkbox"/> CH East Stroudsburg	505 Independence Road	East Stroudsburg, PA 18301	Phone 570-420-8080	Fax 570-420-1704
<input type="checkbox"/> CH Brodheadsville	Rt 115 and Switzgable Drive	Brodheadsville, PA 18322	Phone 570-402-4025	Fax 570-402-3066