CT SINUS FORM

PATIENT NAME:_____ DOB: _____

Are you or could you be pregnant? YES NO

Do you have known allergies? YES NO

Are they environmental or seasonal? ENV SEASON

Please list all allergies:

_____

_____

_____

Have you had any previous exams on your sinuses? YES NO

If yes, when _____ and where_____

Have you had any sinus surgery? YES NO

If yes, when _____ and where_____

Do you have pressure in your sinuses? YES NO
If yes, is it more on the left side or right? Left Right

Do you have headaches? YES NO

Do you wear dentures? YES NO

Technologist notes:

Type of exam: _____

Radiologist called? _____

Protocol given? _____

Notes: _____