



CT AND IV CONTRAST HISTORY AND SCREENING FORM

Today's Date: _____ Referring Physician: _____
Patient Name _____ Sex: Male Female
DOB: _____ Age: _____ Weight: _____ Height: _____

Explain your medical problem in detail that is the reason for you having this CAT Scan test today.
(Where is the problem? How long have you had this problem?)

Have you had a previous exam related to this problem? Yes No. If yes, where was the exam performed? _____

List other medical problems: _____

List previous surgeries: _____

History of Cancer, where? _____

List all allergies: _____

Is there any possibility of pregnancy? _____

CONTRAST HISTORY

List any daily medications: _____

Are you taking Glucophage (a diabetic medication)? Yes No

BUN _____ CREATININE _____

Have you ever had an allergic reaction to X-ray / CT contrast? Yes No

If yes, explain: _____

Any personal history of:

Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Family History of Kidney Failure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Current/Recent IV antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Currently receiving Dialysis /	<input type="checkbox"/> Yes <input type="checkbox"/> No
Single Kidney or Kidney disease, transplant, failure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Myeloma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Transfusions	
		Collagen Vascular Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you breast-feeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Comments: _____

I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that I am not pregnant at this time.

Patient/Parent/Legal Guardian Signature Date _____ Time _____

Witness Signature Date _____ Time _____

Not applicable to this exam <input type="checkbox"/>	
_____ CC of _____	With a _____ at _____ X _____
Lot _____	Expiration Date _____
Site Location _____	By _____
Contrast Reaction <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician Covering Contrast _____
Explain: _____	