CT Patient History Form

MR#______________ **Name**____**Age**_________ **DOB**_________

Appointment Date: ___________ Time ________ Ordering Physician_______________________________

Area of Interest: CT of ____Contrast Y or N **Amt:**_____ **cc**

Diagnosis: ____

CREAT: ____________BUN: ___________STAT _____ Call _________________ Fax ________________
Films: ___Deliver ___ Hand Carry ___ Pick Up

Technologist Notes: ____

____**Tech Initials** ______________

Patient to fill out below information
Indicate the reason you are having this study:

____

Do you have or have you ever had cancer?

____ NO _____YES (If yes, what kind?) ____

Did you receive ***radiation therapy***? ____ No ____ Yes Date of Last Treatment_______

Did you receive ***chemotherapy***? ____ No ____ Yes Date of Last Treatment_______

Indicate imaging studies you have had previously:

Previous CT exam? ____ No ____ Yes When?______________ Where? ____________

Previous MRI exam? ____ No ____ Yes When?______________ Where? ____________

List previous surgery you have had:

_______ None
_______ Cholecystectomy (removal of gallbladder)
_______ Appendectomy (removal of appendix)
_______ Hysterectomy (removal of uterus)
_______ Other (please list surgeries and approximate dates)

Do you have or have you had any of the following?

__**Bronchitis**
__**Asthma**
__**Kidney Disease**
__**Vascular Disease**
__**Sickle Cell Anemia**
__**Liver Disease**
__**Heart Disease**
__**Multiple Myeloma**
__**High Blood Pressure**
__**Current Infection**
__**Chronic Lung Disease**
__**V alley Fever**

__**Diabetes** If yes are you taking any of the following medications:
Yes or **No** *Metaformin* **Yes** or **No** *Glucophage* **Yes or No** *Glucovance*

INFORMED CONSENT FOR CT CONTRAST INJECTION
As part of your scan we may need to inject you with a contrast solution which will highlight the images to provide important diagnostic information. During the injection, you may feel a cool or warm sensation near the injection site or experience a slight metallic taste, which will dissipate after the injection is completed. Although rare, an adverse reaction can occur. In very rare cases, this could be severe. **Have you ever had an allergic reaction to iodine/x-ray dye? ___ No ___ Yes (if yes, what type of reaction?)**____**Are you allergic to any medications and/or medical** supplies? ___ No ___ Yes (please list)____

____ __________________________________
(Signature of Patient/Parent/Guardian) Date