

CT and IV Contrast History & Screening Form

DATE _____

PATIENT _____

SEX: M F

WEIGHT _____ HEIGHT _____ DOB ____/____/____ AGE _____

Explain in detail your medical problem that is the reason for the CT 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 any other medical problems:

List all previous surgeries:

List all allergies:

CONTRAST HISTORY

Are you taking Glucophage, Glucovance, Metformin, Actos Plus Met, Avandamet, Fortamet, Metaglip, Glumetza, Riomet, or Janumet? YES (If yes, Circle Medication above) NO

List of other Medications? _____

Have you ever had an allergic reaction to an X-Ray/CT contrast? YES NO

If Yes, please explain: _____

Any **personal** history of:

- | | | |
|--------------------------------|------------------------------|-----------------------------|
| Asthma | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Kidney Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cancer | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Multiple Myeloma | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Are you on any blood thinners? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Blood Transfusions? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Currently on Dialysis? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

FEMALE PATIENTS

Is there any possibility of pregnancy? YES NO _____ Initial

Are you currently breast feeding? YES 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

 TECHNOLOGIST/WITNESS SIGNATURE

 DATE

NOT APPLICABLE TO THIS EXAM

_____ cc of	_____	_____	_____	_____
<i>Amount</i>	<i>Type of Contrast</i>	<i># of Punctures</i>	<i>Lot #</i>	<i>Expiration Date</i>

CONTRAST REACTION: YES NO Physician Covering Contrast: _____ Tech Initials: _____

EXPLAIN: